Ratios not rationing

UNISON safe staffing report 2017

UNISON
the public service union

Contents

Foreword

News stories highlighting the NHS staffing crisis are sadly a daily occurrence. Nurses are leaving the NHS in droves while fewer EU nurses are registering with the NMC. There has been a significant drop in applicants for nursing courses while the nursing vacancy rate sores to 24,000. Something needs to be done to reverse this trend before it gets any worse and patient safety is put at even greater risk.

UNISON's latest annual staff survey, conducted in February, again shows the number of patients per registered nurse is far too high across all healthcare settings. This is resulting in the quality of patient care and safety being compromised, while missed care and adverse incidents – early indicators of unsafe staffing levels – grow in frequency. Job satisfaction is at an all time low and many nurses are physically, mentally and emotionally exhausted, leading many to consider leaving their chosen profession.

Our findings are mirrored by those in the 2016 NHS staff survey results. Many health workers believe the service is understaffed and this affects their ability to provide care. Out of 409,000 responses to the annual survey, 47% of staff said they either disagreed or strongly disagreed with the statement: "There are enough staff at this organisation for me to do my job properly."

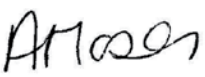
We must ensure that the profession is fit for purpose and remains one that others aspire to join – not one plagued with understaffing and low morale. The comments from frontline staff who worked on that day in February make for depressing reading and paint a picture of a service on its knees.

The government has the power to help the service get back on its feet. We urgently need enough staff to deliver patient care safely and effectively, in a safe environment for employees, patients and their families. That is the message health workers are sending to employers and politicians. We need them to listen and take urgent action to ensure that we have legally binding minimum nurse-to-patient ratios. This will allow staff the time to use their skills and training to deliver high levels of care that will improve patient outcomes and staff morale.

In California, the number of actively licensed registered nurses increased by nearly 100,000 following the enactment of a staffing ratio law. Vacancies for registered nurses plummeted when the ratios were first implemented and turnover and vacancy rates have fallen far below the national average. There has also been a dramatic increase in the number of students interested in nursing as a career. These improvements show that ratios could be the answer to the current staffing crisis in the health service in the UK.

Politicians need to make a decision about the sort of health and social care service this country needs. UNISON is clear that the way ahead is to invest in well trained staff working in a properly funded NHS that puts patients at the heart of everything. That is what UNISON is campaigning for and will continue to do so until that is achieved.

Christina McAnea
UNISON head of health



Ann Moses
Chair of UNISON's nursing and midwifery committee

Executive summary

Background

UNISON's national health group has been campaigning in support of safe staffing levels in healthcare settings for a number of years. As reports, anecdotes and health employees' stories of the consequences of too few staff began to pile up, UNISON's nursing and midwifery committee elected to make safe staffing levels its key priority.

In early 2012, UNISON ran its first safe staffing survey and made public the issues that nursing staff are facing as a result of understaffing.

Objective

This survey aims to highlight the average number of patients a registered nurse cares for on a 'typical' shift, and determine whether this is too high to ensure patient safety and deliver quality of care. We looked at a series of relevant indicators including missed care, the frequency of adverse incidents, the level of job satisfaction and burnout.

It also endeavours to establish whether the approach taken by the government not to enshrine safe staffing levels into law has been effective in ensuring safety on the wards.

Survey method

Nursing staff were asked to tell us about their shift on 7 February by completing an online survey between then and 13 February 2017. The survey received 2,704 responses. It was sent to over 100,000 nursing staff by email on 25 January 2017 and reminders were sent on 6 and 9 February 2017.

Survey results

The average number of patients per registered nurse for all respondents was 13.4. However, this varied significantly by the type of setting and ward. For example, the average number of patients per registered nurse was 5.8 in acute inpatients and 61.9 in community.

Three in five (62.9%) said there were not adequate staff numbers to deliver safe, dignified, compassionate care. Two in five (40.2%) rated the quality of patient care delivered during their shift as poor or fair. Over one-quarter (27.2%) rated patient safety during their shift as failing or poor.

The National Institution for Health and Clinical Excellence (NICE) guide identifies slips, pressure ulcers and medication administration errors as red flag events – an indicator of unsafe staffing levels. Over three in five (60.2%) said slips, trips or falls occurred often or sometimes while almost half (49.4%) said pressure ulcers occurred often or sometimes. Two in five (44.2%) said medication administration errors occurred often or sometimes.

The NICE guide also identifies working overtime, missing breaks and using agency staff frequently as red flag events. Two in five (40.8%) said they worked overtime. Over one-quarter (26.2%) worked more than one additional hour of overtime. Half (50.3%) said they missed all or some of their allocated break or breaks. Almost two-thirds (64.3%) said that agency staff were used often and one-quarter (24.9%) said they were used only sometimes. These are all indicators of unsafe staffing levels.

Another early indicator is missed care. Respondents were more likely to say developing or updating care plans (69.4%), educating patients and family (66.2%) and comforting or talking to patients (63.2%) were rushed, unfinished, not done to an acceptable standard or missed entirely.

Just under half (47.2%) said they were very or a little dissatisfied with their current job. More than half (53.8%) said they would leave their current job if they could but would still carry on nursing. Almost one in 10 (9.9%) said they did not want to carry on nursing at all and increased workloads (72.8%), stress at work (72.4%), and unsafe staffing levels (67.6%) are the most relevant factors in their decision to leave. Disengagement and exhaustion are also factors in their decision to leave.

Almost three in five (58.4%) said they had raised concerns about unsafe staffing levels during their shift. When asked whether their concerns were

listened to, acted upon swiftly, and addressed, almost two-thirds (65.0%) said that had not happened.

While all healthcare settings indicated unsafe staffing levels, the situation appears to be worse for nursing staff working in acute inpatients. Despite the average number of patients per registered nurse being well below the NICE guide's recommendation of no more than eight, almost three-quarters (72%) of respondents in acute inpatients did not feel that there were adequate staff numbers to deliver safe, dignified and compassionate care.

Two in five (41.0%) respondents said they were caring for eight or more patients during their shift – which is deeply concerning given the research that indicates that this is the point at which harm is occurring.

One-third (34%) of respondents rated patient safety as failing or poor, and 46% rated the quality of patient care delivered as poor or fair. Three-quarters (75%) said their ward or unit often used agency or bank staff, half (50%) said they were not able to take their entire break or breaks, and 45% said they worked overtime.

Just under three quarters (73%) of respondents said comforting or talking to patients was unfinished, rushed, not done to a high standard or missed entirely. Only 37% said oral hygiene – and just over half (54%) said administering medication on time – were done to acceptable standards.

Three-quarters (78%) said slips, trips and falls happened often or sometimes during their shift while over two-thirds (68%) said pressure ulcers happened often or sometimes. Over half (54%) said medication administration errors happened often or sometimes.

Half (51%) reported they are very or a little dissatisfied with their current job. Nursing staff working in the acute inpatient setting had the highest average exhaustion (2.89) and disengagement (2.60) scores. Two-thirds (67%) raised concerns about unsafe staffing levels, but seven in 10 (70%) said their concerns were not listened to, acted upon, or addressed. These are all factors relevant to retention.

When the average number of patients per registered nurse by ward was compared with ratios proposed by National Nurses United (NNU) - the largest nurses' union in the USA – only intensive, critical care or neo-natal intensive care wards met the NNU's proposed ratio on 7 February. These staff were less likely to rate patient safety as poor or failing or rate the quality of patient care as poor or fair.

While nursing staff working on intensive, critical care or neo-natal intensive care wards were just as likely to consider leaving their current job as respondents from other wards, unsafe staffing levels were less likely to be a factor in their decision.

The closer the average number of patients gets to the NNU recommendation of four patients per registered nurse for medical or surgical wards, the better the quality of care delivered and the better the patient safety. For example, when asked to rate patient safety, the average number of patients per registered nurse was 4.2 for excellent but 7.3 for failing.

Recommendation

It's clear the government's approach to safe staffing levels is not working. There are not enough nurses to deliver safe, compassionate care and the situation is going to get worse as more consider leaving as a result of burnout and job dissatisfaction.

Ministers should establish and introduce legally binding minimum nurse-to-patient ratios for all healthcare settings similar to those proposed by NNU. When asked whether the government should introduce legally-enforced nurse-to-patient ratios that organisations must comply with, over nine in 10 respondents (93.2%) strongly agreed or agreed.

This would help improve recruitment and retention of nurses and ensure greater workforce stability. There would be better patient care, more manageable workloads, increased job satisfaction, and reduced stress levels. It could also help make the profession more attractive to the next generation of nurses.

Background

Over 450,000 people employed across the health service belong to UNISON. UNISON is proud to be a founding member of the Safe Staffing Alliance, which campaigns for safe staffing levels, and is the union of choice for many nurses across the UK.

This survey is now in its sixth year and forms part of UNISON's longstanding campaign for safe staffing levels in every healthcare workplace. This type of survey is unlike any other. In 2012 it was the first of its kind to 'spot test' staffing levels on a single, 'typical' 24-hour period across the UK. We asked what work was like on Tuesday 7 February 2017, and looked at what this tells us about the problems and challenges nursing staff are facing. We received 2,704 responses, the majority of which were from UNISON members.

We know nurses feel strongly about minimum staffing ratios. When asked whether the government should introduce legally-enforced nurse-to-patient ratios that organisations must comply with, 93.2% strongly agreed or agreed that it should. This is because they recognise that minimum staffing ratios are fundamental to patient safety and quality of care. However, despite a number of reviews into patient safety in England making reference to ratios, the government has refused to introduce them into law.

Reviews into patient safety in England

The Francis Inquiry report (February 2013), examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report found that poor staffing levels – among other factors – led to an inadequate standard of care being offered on some wards. Sir Robert Francis recommended that NICE create evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. He also recommended that the benefits and value for money of possible staff-to-patient ratios should be considered.

In its response to the Francis Inquiry report, the government accepted this recommendation. However, it said the guidance issued would not be expected to include 'absolute staffing ratios given the inflexibility of such an approach, and the potential risks and disadvantages that the rigid application of ratios could have for patient care'.

The government and NHS England asked NICE to develop evidence-based guidelines focusing on nursing care. When developing its first guide on safe staffing for nursing in adult inpatient wards in acute hospitals, NICE considered the findings and recommendations of other reviews, including those by Keogh, Berwick and Cavendish.

The Keogh review into hospital mortality rates found inadequate numbers of nursing staff in a number of ward areas, particularly at night and at the weekend. This was compounded by an over-reliance on unregistered support staff and agency workers. Keogh recommended that the nurse staffing levels and skill mix must reflect the caseload and the severity of illness of the patients being cared for and be transparently reported by trust boards.

The Berwick review into patient safety found that inadequate staffing levels are an early warning sign of poor quality and safety problems. The review also found that general medical or surgical wards with fewer than one nurse to eight patients, plus the nurse in charge, may increase safety risks substantially. It emphasised that this ratio must not be interpreted as an ideal or sufficient standard and that higher acuity (the level of severity of an illness) will require more generous staffing. Berwick recommended that staffing levels should be consistent with the scientific evidence on safe staffing, adjusted to patient acuity and local context, including nurse-to-patient ratios.

The Cavendish review of healthcare assistants and support workers in the NHS found that poor staffing levels were cited as one of the biggest barriers to delivering quality care.

NICE guide on safe staffing in adult inpatient wards in acute hospitals

The NICE guide on safe staffing for nursing in adult inpatient wards in acute hospitals concluded that there is no single nursing staff-to-patient ratio that can be applied across all acute adult inpatient

wards. However, evidence of increased risk of harm associated with a registered nurse caring for more than eight patients during day shifts should be taken into account. Where this happens it should act as a 'red flag event' which would lead to an immediate escalation response by the registered nurse in charge. One appropriate response could be to allocate additional nursing staff to the ward.

The NICE guide is to be read alongside the National Quality Board's (NQB) guidance on staffing capacity and capability. The NQB is responsible for supporting NHS organisations to deliver the right staff, with the right skills to deliver patient care. In the guide, the Chief Nursing Officer (CNO) for England said the debate around whether there should be defined staffing ratios in the NHS 'misses the point – we want the right staff, with the right skills, in the right place at the right time'. She argues that there is 'no single formula or ratio that can calculate the answers to such complex questions'.

The NQB guidance sets out the expectations of NHS providers and commissioners in this area:

1 Boards take full responsibility for the quality of care provided and take responsibility for nurse staffing capacity and capability.

2 Processes are in place to enable staff establishments to be met on a shift-to-shift basis.

3 Evidence based tools are used to inform nurse staffing capacity and capability.

4 Leaders foster a culture of professionalism and responsiveness, where nurses feel able to raise concerns.

5 A multi-professional approach is taken when setting nurse staffing establishments.

6 Nurses have sufficient time to fulfil responsibilities that are additional to their direct caring responsibilities (continual professional development (CPD), mentorship and supervision roles, planned and unplanned leave).

7 Boards review monthly updates on workforce information – and staffing capacity and capability is discussed at a public board at least every six months on the basis of a full nursing establishment review.

8 NHS providers clearly display the number of nursing staff present on each ward, clinical setting, department or service on each shift.

9 Providers of NHS services take an active role in securing staff in line with their workforce requirements.

10 Commissioners actively seek assurances about safe staffing within contractor providers.

Publishing staffing data

NHS England and the Care Quality Commission (CQC) issued joint guidance to trusts on the delivery of expectation eight (above) associated with publishing staffing data regarding nursing, midwifery and care staff levels. The guidance also covered the frequency with which boards and trusts need to display and evaluate staffing data and publish their reports online, and the dates when stock takes of their progress will be undertaken.

To summarise, the displays should:

- be in an area within the clinical area that is accessible to patients, their families and carers
- explain the planned and actual numbers of staff for each shift (registered and non-registered)
- detail who is in charge of the shift
- describe what each member of the team's role is
- be accurate.

The NICE guide on safe staffing in adult inpatient wards in acute hospitals identifies planned, required and available nurses for each shift as an indicator of unsafe staffing levels.[1] However, analysis of quarterly hospital-level staffing data by Health Service Journal found that 214 acute hospitals – 96% of those reporting – failed to meet their own planned level for registered nurses working during the day in October 2016.[2] This is the worst

1 https://www.nice.org.uk/guidance/sg1/chapter/9-Safe-nursing-indicators#safe-nursing-indicator-planned-required-and-available-nurses-for-each-shift

2 https://www.nursingtimes.net/news/workforce/revealed-the-hospitals-with-the-worst-nurse-staffing/7014987.article

performance for both day and night since Health Service Journal started collecting data in 2014.

The majority of hospitals that were below their planned staffing levels for nurses were at or above their plan for healthcare assistant staffing. This suggests that some sites might be filling gaps in the nursing workforce with less qualified staff. Higher numbers of healthcare assistants has been linked with increased patient mortality.[3]

NICE guide on safe midwifery staffing for maternity settings

NICE also published guidance on safe maternity staffing for maternity settings. The guidance recommends one-to-one care during established labour (not necessarily the same midwife for the whole labour) and more than one-to-one care during established labour if circumstances require it. If one midwife is not able to provide continuous one-to-one care and support to a woman during established labour, this is a midwifery red flag event. This is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge should be notified and should determine whether midwifery staffing is the cause, and identify the action that is needed.

NICE work on safe staffing suspended

NHS England and the government asked NICE to suspend its safe staffing work in 2015. The move sparked widespread anger and concern within the nursing profession. At the time of the suspension, NICE had completed, but not yet published, guidance for accident and emergency units and was in the process of collecting evidence for guidelines on community services and mental health. In January 2016, the Health Service Journal reproduced the NICE guidance on safe staffing in accident and emergency departments from a leaked document.[4] For the first time, the guidance recommended nurse to patient ratios for a healthcare setting.

Sir Robert Francis expressed serious concerns over the decision to suspend the programme of work that he recommended to determine safe nurse staffing levels.[5] However, the new body NHS Improvement – formed from a merger of Monitor and the NHS Trust Development Authority – is now undertaking this work on safe staffing and has already published some draft guides this year which he said were "suspiciously" similar to the work suspended by NICE[6]. While NHS Improvement is taking a multi-disciplinary team approach rather than focusing on nursing staff – an approach UNISON supports – it will not set a minimum nurses to patients ratio.

Enshrining safe staffing into law

While guidance developed in England is not mandatory and does not make recommendations regarding ratios, other devolved nations have passed, or plan to pass, legislation enshrining safe staffing into law, which takes ratios into consideration. Wales has become the first nation in Europe to pass a law ensuring nurses on adult acute medical inpatient wards and surgical wards have the time to deliver safe, effective and quality care.

The Nurse Staffing Levels (Wales) Act 2016 requires health boards to ensure "sufficient" nurse staffing levels are maintained at a level that has been calculated using the professional judgement of the nurse in charge of the shift, a workforce tool to ensure the acuity of patients is considered, and in a way that takes into account recommended staffing ratios. The Act also contains powers to extend this legal requirement to other settings such as mental health wards and community settings. The law will come into effect once Welsh ministers bring in a statutory instrument that provides more detail on how the legislation should be complied with.

One of the main driving forces behind the legislation was that its introduction would in itself improve retention and recruitment because international evidence showed similar nurse staffing legislation in other countries had proven to be a powerful tool for attracting more nurses into the profession. Furthermore, the inadequate supply of student nurses seen in the past should not be repeated under the new legislation because it requires health boards to carry out accurate workforce planning

3 https://www.hsj.co.uk/topics/quality-and-performance/higher-number-of-hcas-linked-with-increased-mortality-says-study/7002227.article

4 https://www.hsj.co.uk/7001696.article

5 https://www.nursingtimes.net/roles/nurse-managers/francis-criticises-cessation-of-nice-work-on-safe-staffing-guidance/5086602.article

6 https://www.nursingtimes.net/news/policies-and-guidance/current-nhs-pressures-make-another-mid-staffs-inevitable/7015558.article

that supports safe staffing. The law's introduction would also see more initiatives introduced by employers to improve nurse retention.

Scotland has developed mandatory nursing and midwifery workload and workforce planning tools that help health boards plan for the number of staff they require. In June 2016, the Scottish government announced it would make it a legal requirement for health boards to use these nursing and midwifery workforce planning tools to calculate staffing levels. The Scottish government will also examine what other areas of the workforce would benefit from having similar tools developed, which will further strengthen its commitment to patient safety.

Impact of mandatory ratios in other countries

Other countries have gone a step further and passed legislation enshrining specified ratios into law. In Victoria (Australia) minimum nurse-to-patient ratios became legally binding in the public sector in 2001 (1:4, plus one in charge on medical or surgical wards). In 2004 the way in which the registered nurse to patient ratio was expressed was changed to 5:20 to give more flexibility on registered nurse deployment across the ward. The Australian Nursing Federation (ANF) reports that ratios have led to:

- better recruitment and retention of nurses and greater workforce stability
- adequate numbers of nurses rostered six weeks in advance
- directors of nursing having fully funded budgets to provide safe staffing levels, and a reduced reliance on agency staff
- better patient care, beds not kept open unless there are sufficient staffing levels
- more manageable nursing workloads
- increased job satisfaction for nurses, more workplace stability, and reduced stress.

In California, ratios of 1:5 on medical and surgical wards were set in 1999. To date 15 more states have legislation aimed at addressing safe nurse staffing, but California is the only state to have specific ratios applying to each speciality in all hospitals. There is no evidence that the introduction of these ratios increased costs and hospital nurses typically care for one patient fewer than nurses in other states. This lower case load is significantly related to lower patient deaths.[7]

After the staffing ratio law came in the number of actively licensed registered nurses in California increased from 246,068 in June 1999 to 345,497 in November 2008. The number of actively licensed registered nurses has grown by an average of more than 10,000 a year, compared to fewer than 3,000 a year prior to the law. Vacancies for registered nurses at Sacramento area hospitals have plummeted 69% since early 2004 when the ratios were first implemented. And across the state many of the biggest hospital systems have seen their turnover and vacancy rates fall below 5%, far below the national average. The ratios have also helped to fuel a dramatic growth in student interest in nursing. California nursing programmes have expanded greatly in the years since the ratio law was enacted, as the profession has become more attractive[8].

NNU[9] is campaigning for unit-specific registered nurse-to-patient ratios for acute-care hospitals across the United States of America.[10] The campaign calls for:

- registered nurse-to-patient ratios for all shifts at all times without averaging
- prohibition on using mandatory overtime to meet ratio requirements
- restrictions on use of unlicensed assistive personnel
- patient classification system to determine additional staff, based on an acuity tool
- monetary fines for violations
- if a state imposes more favourable ratios, this law shall not override the state law
- publicly posted ratios.

7 http://www.kcl.ac.uk/nursing/research/nnru/policy/Policy-Plus-Issues-by-Theme/Whodeliversnursingcare(roles)/PolicyIssue34.pdf

8 http://nurses.3cdn.net/9f8acc26adbb3c5180_d4m6b3jec.pdf

9 http://www.nationalnursesunited.org/pages/ratios-assessment

10 http://nurses.3cdn.net/d03910067cd1338568_vtm6i2k75.pdf

As part of the campaign, NNU proposed the following registered nurse ratios:

Intensive or critical care	1:2
Neo-natal intensive care	1:2
Operating room	1:1
Post-anaesthesia	1:2
Labour and delivery	1:2
Antepartum	1:3
Combined labour and delivery and postpartum	1:3
Well baby nursery	1:6
Postpartum couplets	1:3
Intermediate care nursery	1:4
Paediatrics	1:3
Emergency room	1:3
Trauma patient in ER	1:1
ICU patient in ER	1:2
Step down	1:3
Telemetry	1:3
Medical or surgical	1:4
Coronary care	1:2
Acute respiratory care	1:2
Burn unit	1:2
Other speciality care units	1:4
Psychiatric	1:4
Rehabilitation	1:5
Skilled nursing facility	1:5

Objectives

This survey will help to establish whether the approach taken by the UK not to enshrine safe staffing levels into law, instead providing non-mandatory guidance or workforce planning tools has been effective. While Wales has enshrined safe staffing into law and Scotland intends to do the same, the impact of the legislative change has not yet been felt because it has not been fully implemented.

The main objectives of this survey are to:

1. Identify the number of patients per registered nurse by setting and ward during their shift on 7 February 2017.

2. Establish other factors relevant to unsafe staffing levels such as the frequency of agency workers, missed breaks and use of overtime.

3. Determine the quality of patient care delivered and whether patient safety is being put at risk.

4. Consider the frequency of missed care and adverse events which act as early warnings that staffing levels are unsafe.

5. Look at the level of job dissatisfaction and burnout (exhaustion and disengagement) and its links with unsafe staffing levels and staff retention.

Survey method

UNISON has been campaigning on safe staffing levels in healthcare settings for a number of years. The reports, anecdotes and stories of the consequences of too few staff continue to pile up which means this campaign continues to be a priority.

The survey questions were written with the help of UNISON's nursing and midwifery committee – a panel from across the country with backgrounds in all major areas of nursing and midwifery, including academia.

The survey asked people to record details about their shift during a particular 24-hour period. This type of 'spot test' survey, performed across the country on the same day, remains the only one of its kind. What it has unearthed consistently over the last six years is that nothing has changed; nursing staff everywhere are feeling the pressure of service cuts, making care delivery more difficult. Government rhetoric that there are more nurses than ever working in the NHS is the opposite of the experience of nurses on the frontline.

The survey has maintained a consistent format over the previous five years. However, this year the number of questions was reduced and simplified. Much like the first survey (6 March 2012), the 2017 survey asked respondents to record details about their shift during the same 24-hour period. This year the online survey ran over a 24-hour period on Tuesday 7 February 2017. We chose this to ensure the data would not be skewed by pressures from emergency weekend admissions or higher demand for services during the depths of winter.

The survey contained 45 questions. Most were multiple-choice and centred around five primary topics:

- the number of patients per registered nurse by setting and ward during their shift on 7 February 2017
- the quality of patient care delivered and patient safety rating
- the frequency of missed care and adverse events
- the level of job dissatisfaction and burnout
- other factors relevant to unsafe staffing levels such as the frequency of agency workers, missed breaks and use of overtime.

UNISON received 2,704 unique responses to the survey. A copy of the survey questionnaire is available in appendix B.

The survey was open to non-members as well as nursing staff belonging to UNISON.

The survey was designed to provide a clear picture of the situation faced by those working in nursing. UNISON receives regular reports about frustrations with the inadequate ratio of nurses to patients, and the effect this has on patient care, and on fair treatment of staff. Mandatory staffing levels have proven to have positive effects in both these areas internationally.

Survey results

Patients per registered nurse

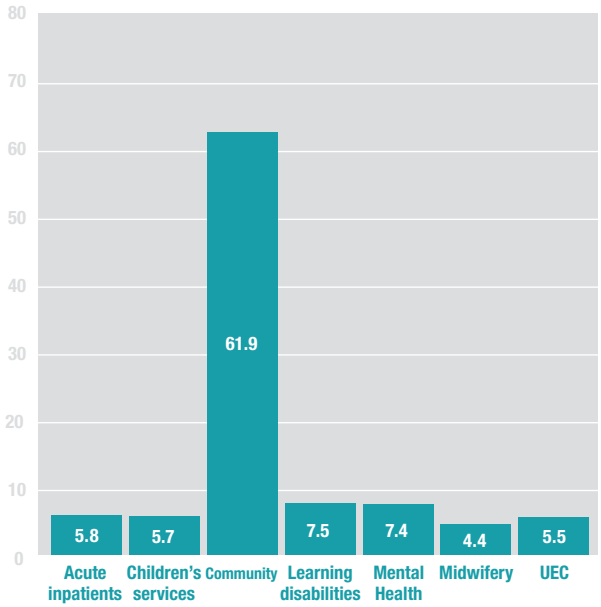
The average number of patients per registered nurse was 13.4. Almost two-thirds (65.3%) said it was a 'typical' shift. Two-thirds (66.3%) worked a day shift, one-quarter (25.2%) a night shift, and 8.5% an afternoon or evening shift. Two in five (40.6%) said they were rostered to work 12 or more hours during their shift.

However, it is recognised that different healthcare settings may require different numbers of nursing staff. This is because the needs of the patient will differ depending on the type of setting or ward. Therefore, in order to get a more accurate picture, it is necessary to look at the average number of patients per registered nurse in different settings and ward types. We will begin by looking at the different settings – acute inpatients, mental health, midwifery, learning disabilities, community, urgent and emergency care and children's services.

When asked what type of setting they worked in during their shift on Tuesday 7 February 2017, over one-third of respondents (37.2%) said that it was in acute inpatients. Another 14.9% said they worked in mental health, 9.8% in community, 3.1% in emergency and urgent care, 2.1% in children's services, 1.8% in learning disabilities, and 0.8% in midwifery. Three in 10 respondents (30.4%) selected other including care and nursing homes.

The average number of patients per registered nurse was 5.8 in acute inpatients, 5.7 in children's services, 61.9 in community, 7.5 in learning disabilities, 7.4 in mental health, 4.4 in midwifery and 5.5 in urgent and emergency care (table 1.1). Two in five (41%) respondents in acute inpatients said they were caring for eight or more patients during their shift, which is deeply concerning given the research that indicates that this is the point at which harm is occurring.

Table 1.1: Average number of patients per registered nurse



When asked whether their shift on 7 February 2017 was a typical one, over three-quarters (77.3%) in community, 72.3% in learning disabilities, 69.2% in mental health, 63.6% in midwifery, 63.4% in acute inpatients, 62.7% in urgent and emergency care and 60.7% in children's services said it was. This means that the majority of respondents across all settings said their shift was a typical one.

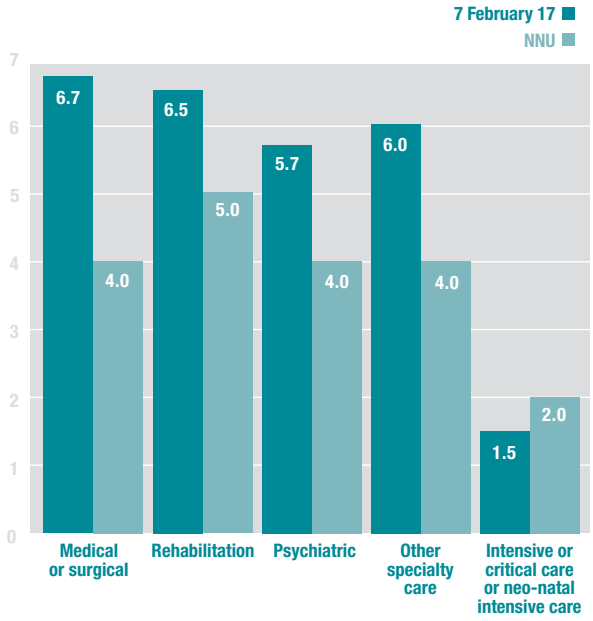
When asked what type of shift they worked on 7 February 2017, four in five (83.2%) in community, over three-quarters (77.3%) in midwifery, over three-quarters (77.2%) in children's services, two-thirds (66.0%) in learning disabilities, two-thirds (65.9%) in urgent and emergency care, 62.4% in acute inpatients, and three in five (60.6) in mental health said they worked a day shift. This means the majority of respondents across all health settings said they worked a day shift. Night shifts were worked more frequently by nursing staff in acute inpatients (32.1%), urgent and emergency care (29.3%), and learning disabilities (25.5%).

Working hours varied quite considerably depending on the type of setting. 12 hour or more shifts were more frequently worked by nursing staff in midwifery (63.6%), acute inpatients (54.7%), and urgent and emergency care (51.8%). Shifts between six to eight hours long were more likely to be worked by nursing staff in community (56.1%), mental health (38.3%), and learning disabilities (29.2%). We

will now go on to look at different ward types.

The majority of respondents worked on five different ward types – medical or surgical, rehabilitation, psychiatric, other speciality care, and intensive or critical care or neo-natal intensive care. The average number of patients per registered nurse was 6.7 on medical or surgical wards, 6.5 on rehabilitation wards, 5.7 on psychiatric wards, 6.0 on other speciality care wards, and 1.5 on intensive or critical care or neo-natal intensive care wards. The average number of patients per registered nurse was then compared with the ratios proposed by NNU. Only the patients per registered nurse on intensive or critical care or neo-natal intensive care units are within the ratio proposed by NNU (table 1.2).

Table 1.2: NNU proposed ratios compared with patients per registered nurse



When asked whether their shift on 7 February 2017 was a typical one, 69.2% on rehabilitation wards, 68.0% on psychiatric wards, 62.7% on other speciality care wards, 62.2% on medical or surgical wards, and 55.2% on intensive or critical care or neo-natal intensive care wards said it was.

When asked what type of shift they worked on 7 February 2017, almost three-quarters (74.1%) on other speciality care wards, 65.5% on medical or surgical wards, 58.3% on psychiatric wards, 54.4% on rehabilitation wards, and 53.8% on intensive or critical care or neo-natal intensive care wards said they worked a day shift. This means the majority of respondents from all ward types said they had worked a day shift. Respondents working on intensive or critical care or neo-natal intensive care wards (39.6%), rehabilitation wards (54.4%), and medical or surgical wards (30.2%) were more likely to have worked a night shift.

The number of hours respondents were rostered to work on their shift varied. Respondents working on medical or surgical wards (56.5%) and intensive or critical care or neo-natal intensive care wards (55.7%) were more likely than respondents from other ward types to work 12 hours or more, while respondents working on psychiatric wards (41.4%) were more likely to work six to eight hours on their shift.

Other factors

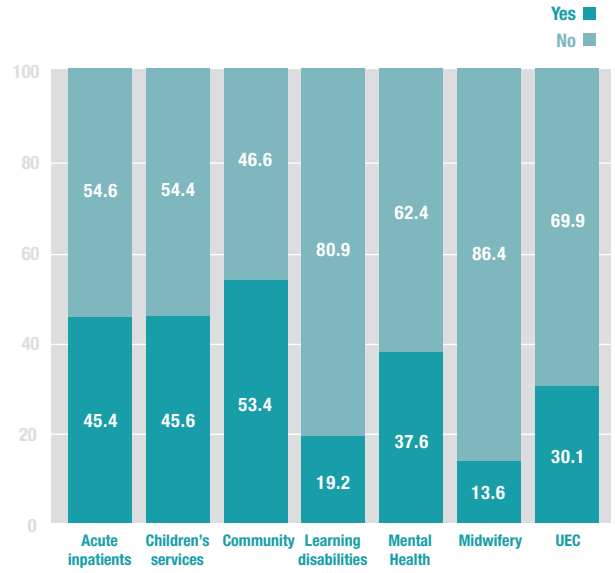
The NICE guide on safe staffing in adult inpatient wards in acute hospitals identifies nursing staff working extra hours, being unable to take scheduled breaks, and high levels and ongoing reliance on temporary nursing as indicators of unsafe staffing levels.[11]

Two in five (40.8%) said they worked overtime. Over one-quarter (26.2%) worked more than one additional hour of overtime. Half (50.3%) said they missed all or some of their allocated break or breaks. Almost two-thirds (64.3%) said that agency staff were used often and one-quarter (24.9%) said they were used only sometimes.

When we looked at different settings, the amount of overtime worked varied. Respondents were more likely to say they worked longer than their rostered working hours if they worked in community (53.4%), children's services (45.6%), and acute inpatients (45.4%). Nursing staff working in midwifery (86.4%), learning disabilities (80.9%), and urgent and emergency care (69.9%) were less likely to work overtime (table 2.1).

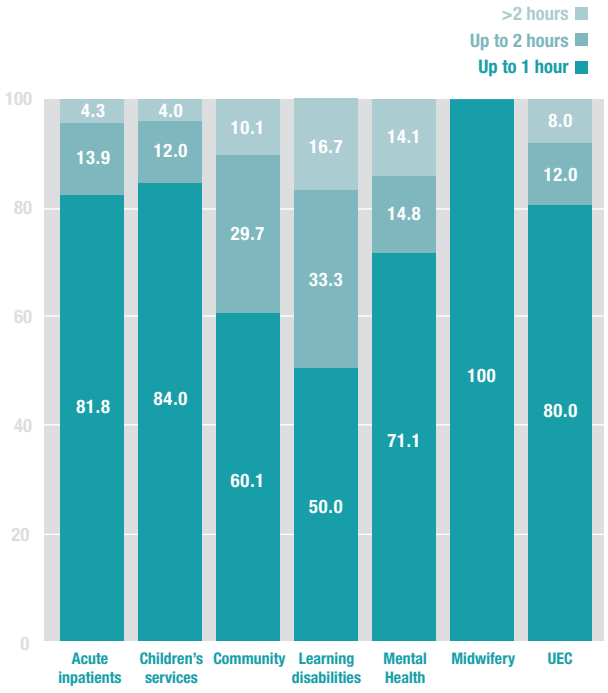
11 https://www.nice.org.uk/guidance/sg1/chapter/9-Safe-nursing-indicators#safe-nursing-indicator-high-levels-andor-ongoing-reliance-on-temporary-nursing

Table 2.1: Did you work longer than your rostered hours?



Respondents working in learning disabilities (50.0%), community (39.9%), and mental health (28.9%) were more likely to work more than one additional hour of overtime (table 2.2).

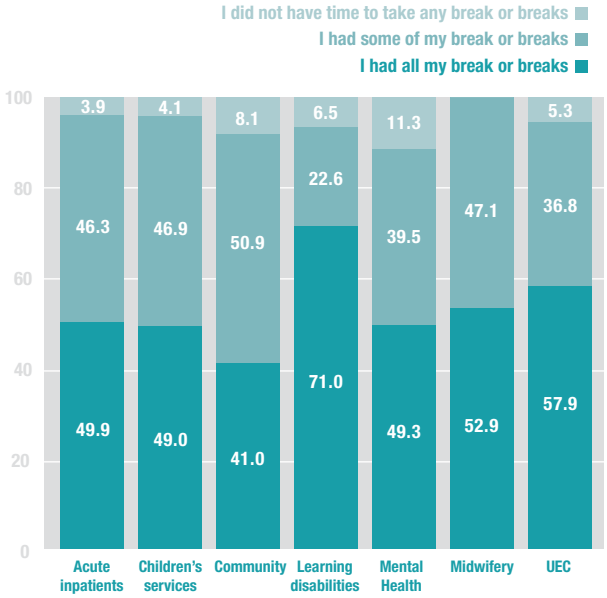
Table 2.2: How many additional hours did you work?



Respondents working in community (62.3%), mental health (66.0%), and learning disabilities (66.7%) were less likely to work a shift that included one or more breaks. This may be because nursing staff in these settings were less likely to work longer shifts and therefore may be less likely to qualify for one break or more.

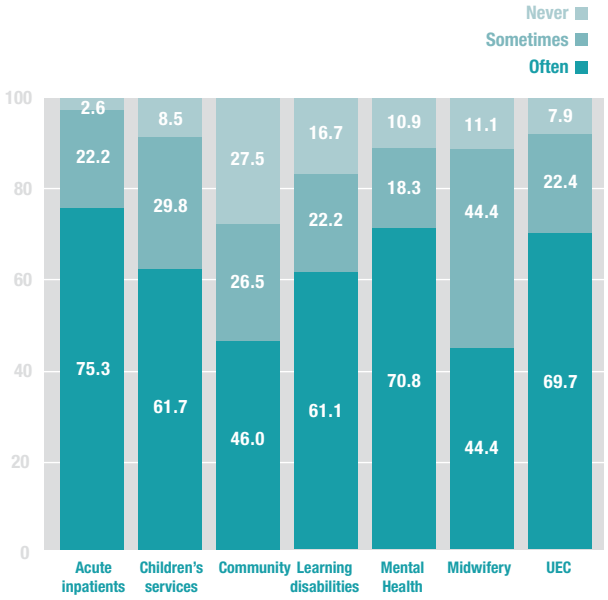
Respondents working in community (41.0%), children's services (49.0%), mental health (49.3%), and acute inpatients (49.9%) were less likely to have taken all their break or breaks (table 2.3).

Table 2.3: Did you have time to take your allocated break or breaks during your shift?



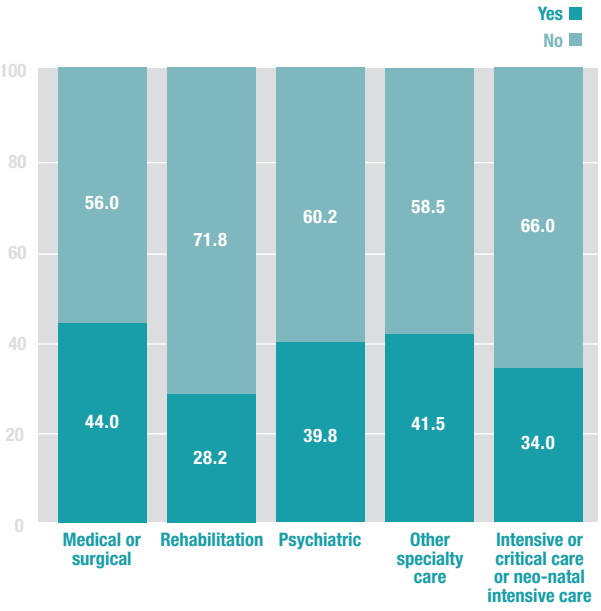
When asked how frequently their ward or unit used bank or agency staff during their shift, the majority of respondents from all settings said that agency staff were used sometimes or often. However, respondents working in acute inpatients (97.5%), urgent and emergency care (92.1%), and children's services (91.5%) were more likely to say that their ward or unit used bank or agency staff sometimes or often during their shift (table 2.4). We will now go on to look at how these responses varied by ward type.

Table 2.4: How frequently does your ward or unit use bank or agency staff?



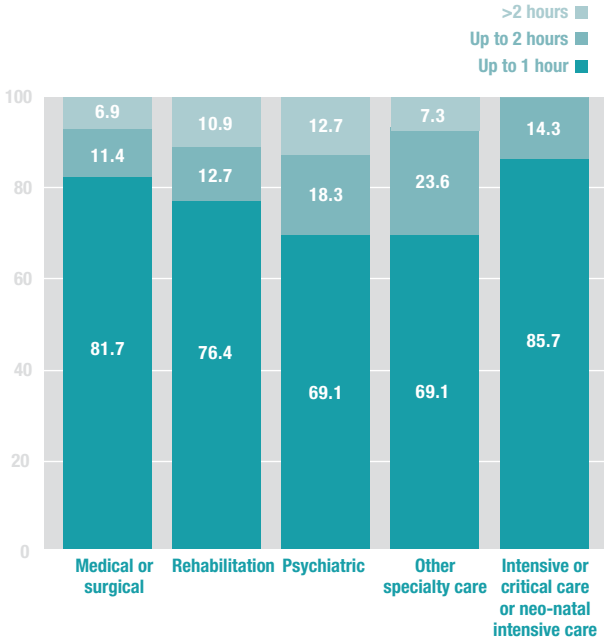
While the majority of respondents from all ward types said they did not work longer than their rostered hours, respondents working on medical or surgical wards (44.0%) and other speciality care wards (41.5%) were more likely than respondents from other ward types to say they had worked longer than their rostered hours (table 2.5).

Table 2.5: Did you work longer than your rostered hours?



When those who worked overtime were asked how many additional hours they worked, the majority of respondents from all ward types said they had worked up to one hour longer. Respondents working on psychiatric wards (12.7%) and rehabilitation wards (10.9%) were more likely than respondents from other ward types to work over two hours longer (table 2.6).

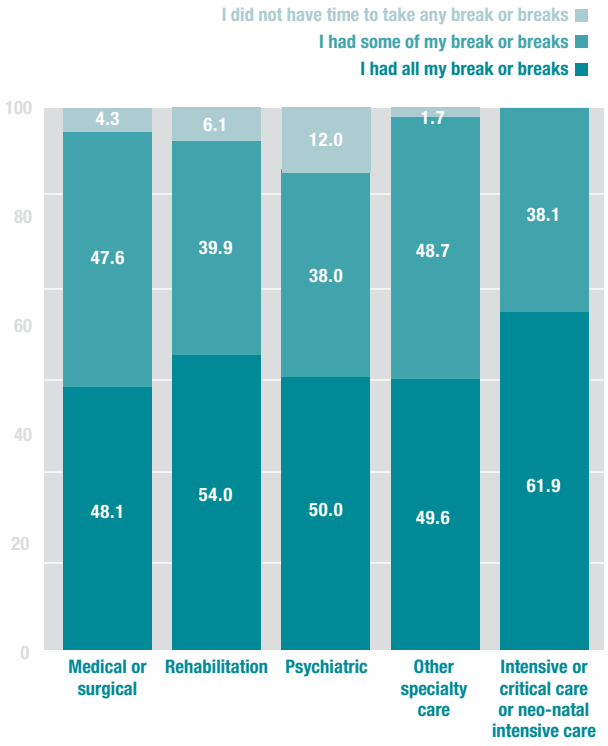
Table 2.6: How many additional hours did you work?



The majority of respondents from all ward types said their shift included one or more breaks. However, respondents working on psychiatric wards (35.1%) were more likely than others to say their shift did not include one or more breaks. This may be because respondents working on psychiatric wards were more likely to work short hours during their shift and therefore were more likely to not qualify for a break.

When those whose shift included one or more breaks were asked whether they had time to take their allocated break or breaks during their shift, the response varied depending on the ward type. Respondents working on medical or surgical wards (48.1%) and psychiatric wards (50.0%) were less likely than respondents from other ward types to have all their break or breaks. Respondents working on intensive or critical care or neo-natal intensive care wards (61.9%) were more likely than respondents from any other ward type to have had all their break or breaks (table 2.7).

Table 2.7: Did you have time to take your allocated break or breaks during your shift?



Early warnings

Missed care can be an early warning measure to identify settings with inadequate nurse staffing.[12] Below is the percentage of respondents that said the following tasks were done to an acceptable standard during their shift:

- comfort or talk with patients (36.8%)
- educating patients and family (33.8%)
- develop or update nursing care plans or care pathways (30.6%)
- adequate patient surveillance (46.1%)
- adequately document nursing care (44.8%)
- oral hygiene (39.9%)
- frequent changing of patient position (51.1%)
- planning care (42.6%)
- administer medications on time (61.1%)
- skin care (52.3%)
- prepare patients and families for discharge (38.3%)
- treatments and procedures (58.2%)
- pain management (66.9%).

Respondents were more likely to say developing or updating care plans (69.4%), educating patients and family (66.2%) and comforting or talking to patients (63.2%) was rushed, unfinished, not done to an acceptable standard or missed entirely.

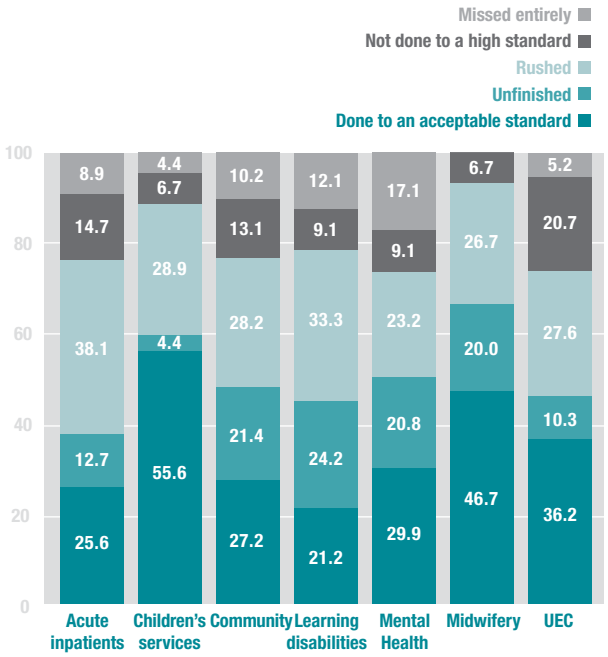
The NICE guide on safe staffing in adult inpatient wards in acute hospitals identifies a lack of falls, pressure ulcers, and medication administration errors as safe nursing indicators.[13] Below is the percentage of respondents that said the following adverse incidents occurred often or sometimes during their shift: slips, trips or falls (60.2%); pressure ulcers (49.4%); and medication administration errors (44.2%). We will now go on to look at how responses varied by different settings.

When asked whether they had developed or updated nursing care plans or pathways during their shift, the majority of respondents across all settings (except children's services) said the task was either unfinished, rushed, not done to a high standard or missed entirely. Respondents working in learning disabilities (21.2%), acute inpatients (25.6%), and community (27.2%) were less likely to say that the task had been done to an acceptable standard (table 3.1).

12 http://qualitysafety.bmj.com/content/early/2013/07/08/bmjqs-2012-001767

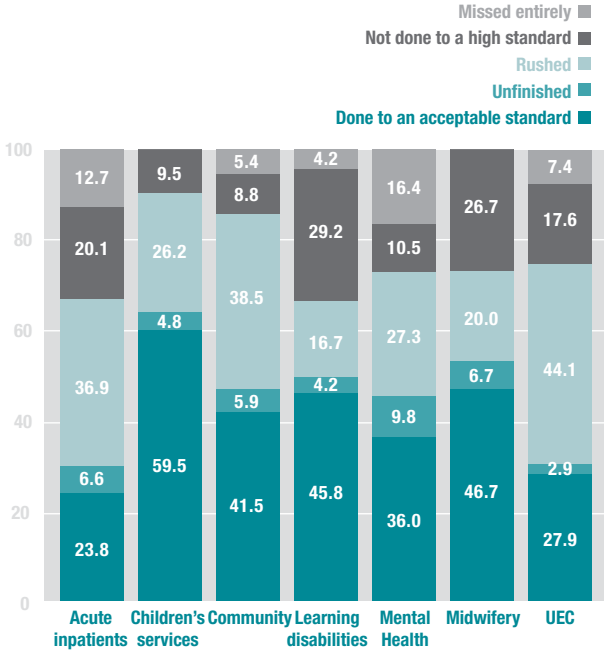
13 https://www.nice.org.uk/guidance/SG1/chapter/9-Safe-nursing-indicators

Table 3.1: Develop or update nursing care plans or care pathways



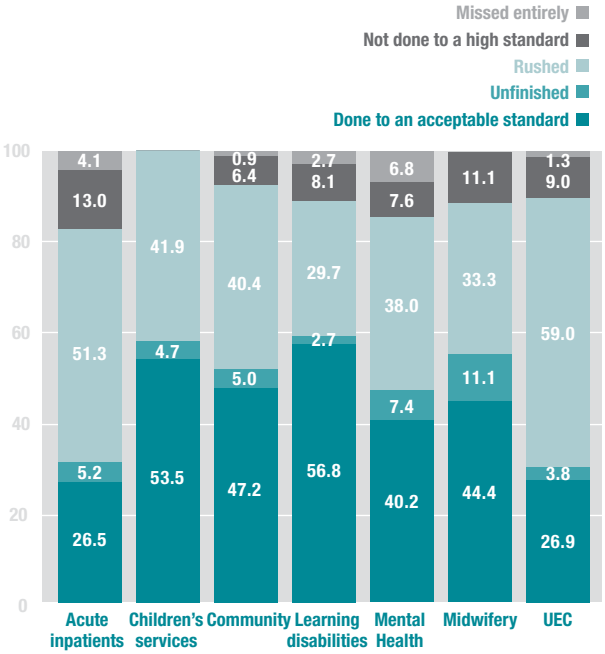
When asked whether they had educated patients and families during their shift, the majority of respondents across all settings (except children's services) said the task was either unfinished, rushed, not done to a high standard or missed entirely. Respondents working in acute inpatients (23.8%), urgent and emergency care (27.9%), and mental health (36%) were less likely to say the task had been done to an acceptable standard (table 3.2).

Table 3.2: Educating patients and family



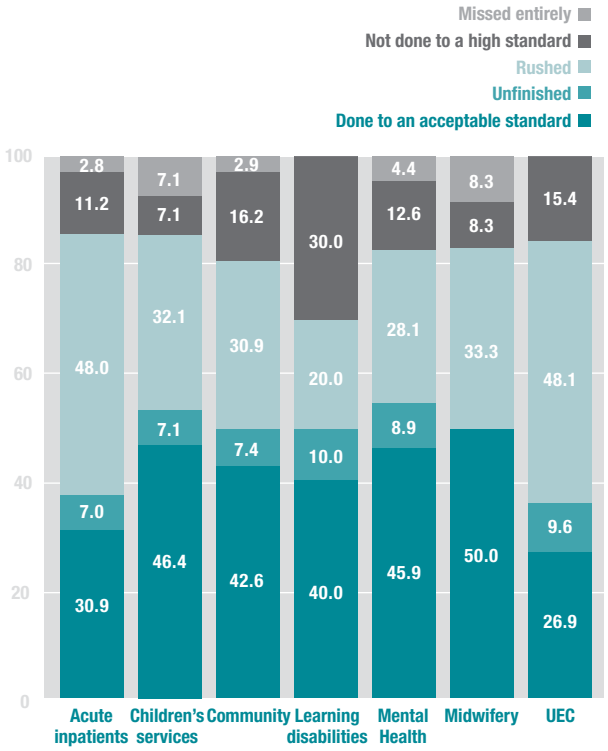
When asked whether they had comforted or talked to patients during their shift, the majority of respondents across all settings (except children's services and learning disabilities) said that the task was either unfinished, rushed, not done to a high standard or missed entirely. Respondents working in acute inpatients (26.5%), urgent and emergency care (26.9%), and mental health (40.2%) were less likely to say the task had been done to an acceptable standard (table 3.3).

Table 3.3: Comfort or talk with patients



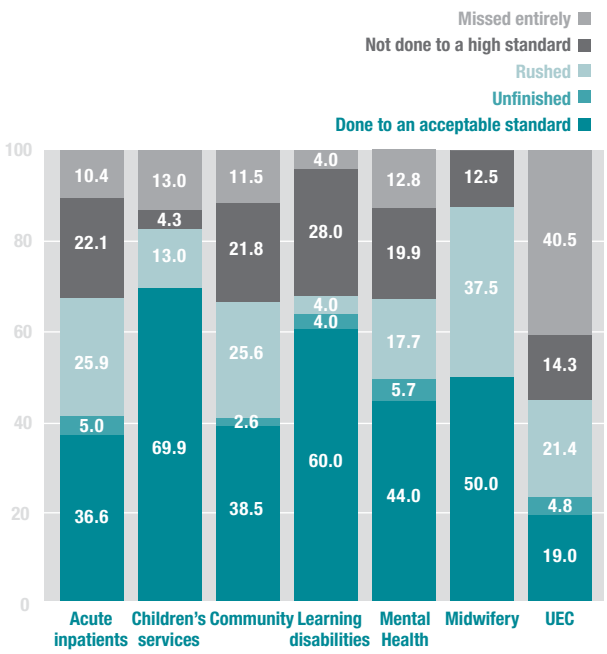
When asked whether they had prepared patients and families for discharge during their shift, the majority of respondents across all settings said that the task was either unfinished, rushed, not done to a high standard or missed entirely. Respondents working in urgent and emergency care (26.9%), acute inpatients (30.9%), and learning disabilities (40.0%) were less likely to say the task had been done to an acceptable standard (table 3.4).

Table 3.4: Prepare patients and families for discharge



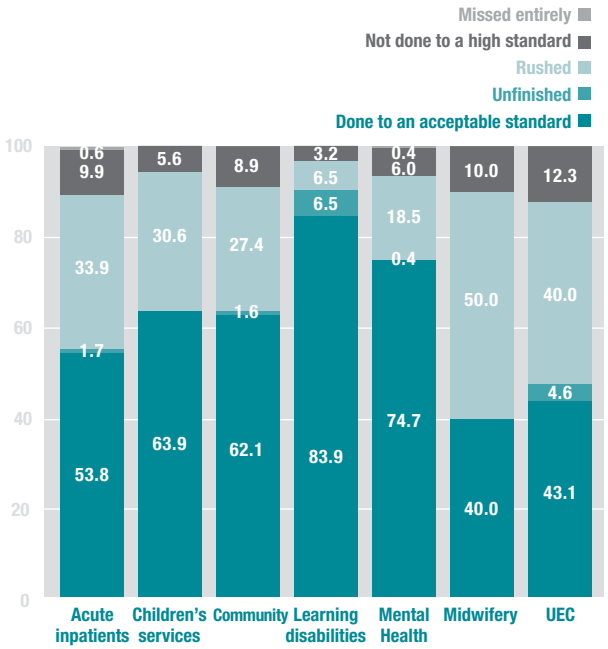
When asked whether they had undertaken patients' oral hygiene during their shift, the majority of respondents across all settings (except children's services and learning disabilities) said that the task was either unfinished, rushed, not done to a high standard or missed entirely. Respondents working in urgent and emergency care (19.0%), acute inpatients (36.6%), and community (38.5%) were less likely to say the task had been done to an acceptable standard (table 3.5).

Table 3.5: Oral hygiene



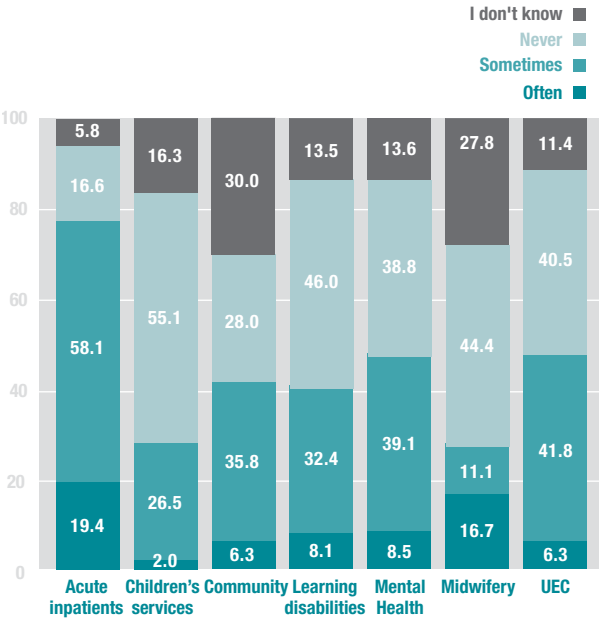
When asked whether they had administered medications on time during their shift, the majority of respondents across most settings said that the task had been done to an acceptable standard. However, respondents working in midwifery (40.0%), urgent and emergency care (43.1%), and acute inpatients (53.8%) were less likely to say the task had been done to an acceptable standard and more likely to say it had been unfinished, rushed or not done to a high standard (table 3.6).

Table 3.6: Administer medications on time



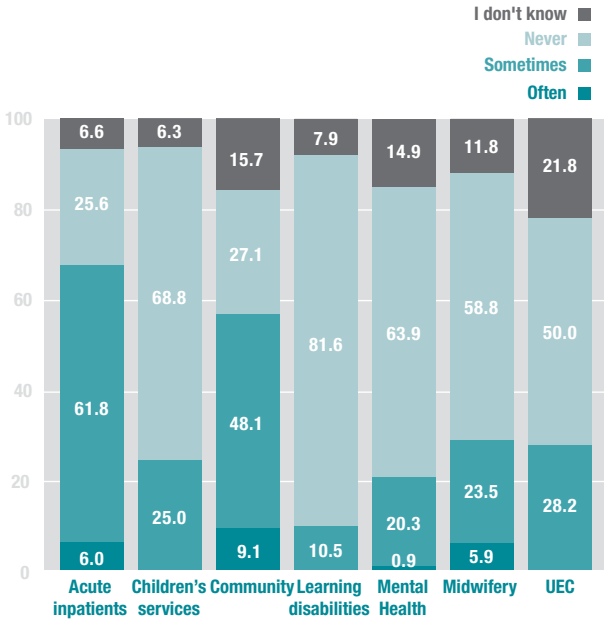
When asked how frequently slips, trips and falls occurred during their shift, the responses varied. However, respondents working in acute inpatients (77.5%), urgent and emergency care (48.1%), and mental health (47.6%) were more likely to say that slips, trips and falls occurred often or sometimes during their shift (table 3.7).

Table 3.7: Slips, trips and falls



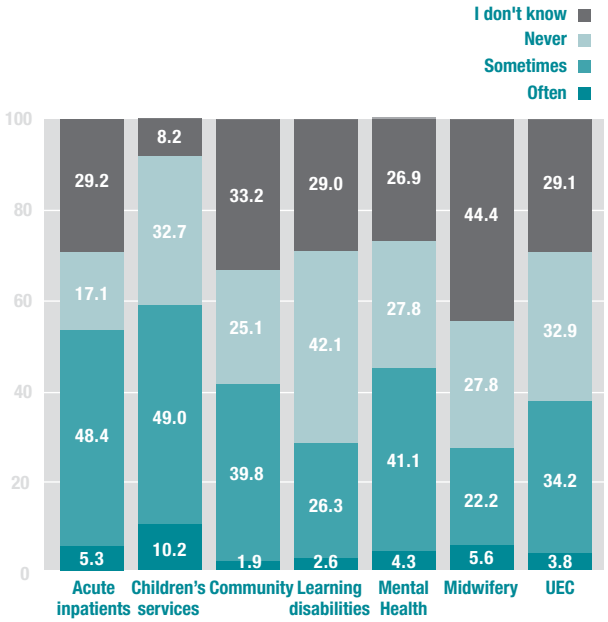
When asked how frequently pressure ulcers occurred during their shift, the responses varied. However, respondents working in acute inpatients (67.8%), community (57.2%), and midwifery (29.4%) were more likely to say that pressure ulcers occurred often or sometimes during their shift (table 3.8).

Table 3.8: Pressure ulcers



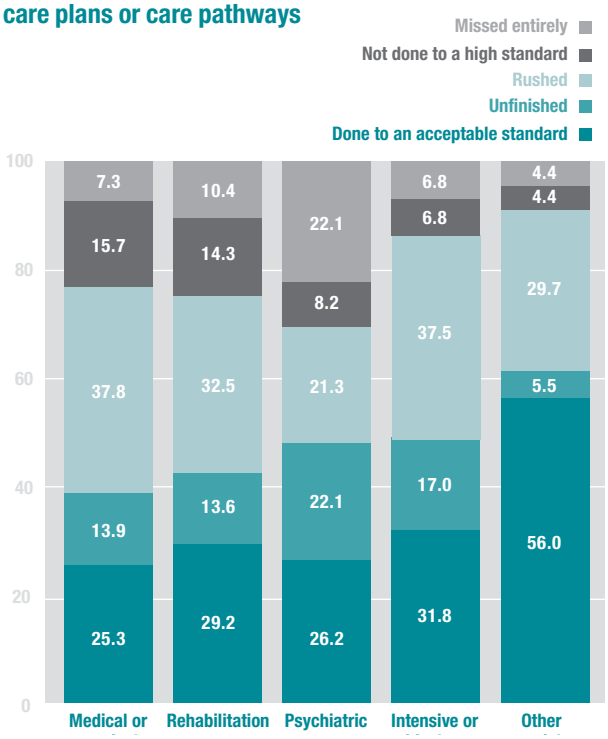
When asked how frequently medication administration errors occurred, the responses varied. However, respondents working in children's services (59.2%), acute inpatients (53.7%), and mental health (45.4%) were more likely to say medication administration errors occurred often or sometimes during their shift (table 3.9). We will now go on to look at how the responses varied by ward.

Table 3.9: Medication administration errors



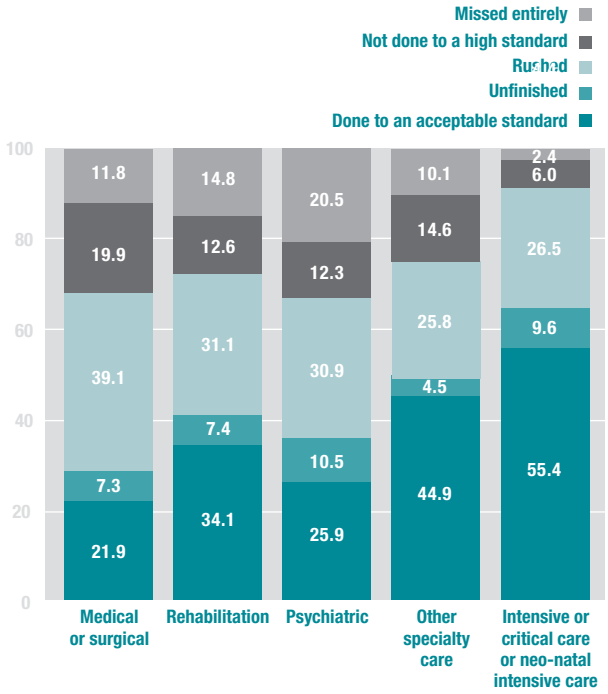
When asked whether they had developed or updated nursing care plans or pathways during their shift, respondents working on intensive or critical care or neo-natal intensive care wards (56.0%) were more likely than respondents from any other ward type to say the task had been done to an acceptable standard. Respondents working on medical or surgical wards (74.7%) were more likely to say the task was unfinished, rushed, not done to a high standard or missed entirely (table 3.10).

Table 3.10: Develop or update nursing care plans or care pathways



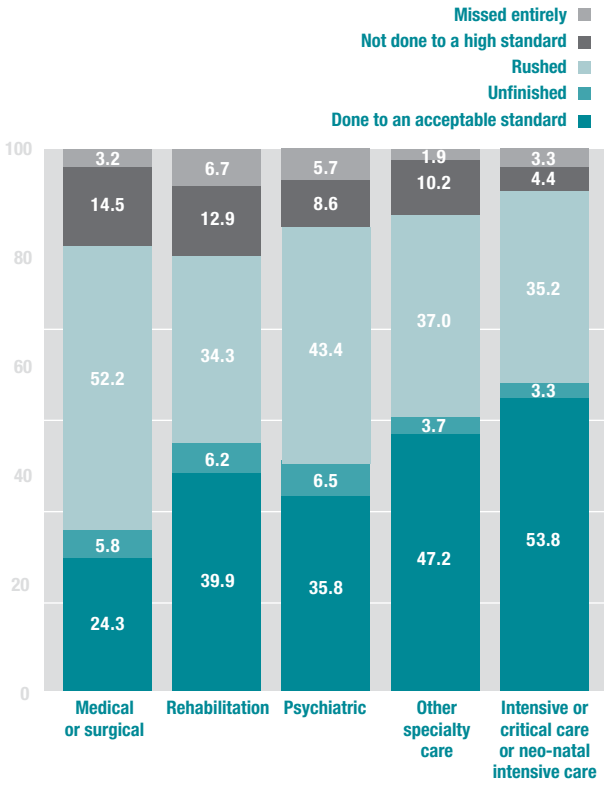
When asked whether they had educated patients and family during their shift, respondents working on intensive or critical care or neo-natal intensive care wards (55.4%) were more likely than respondents from any other ward type to say the task had been done to an acceptable standard. Respondents working on medical or surgical wards (78.1%) were more likely to say that the task was unfinished, rushed, not done to a high standard or missed entirely (table 3.11).

Table 3.11: Educating patients and family



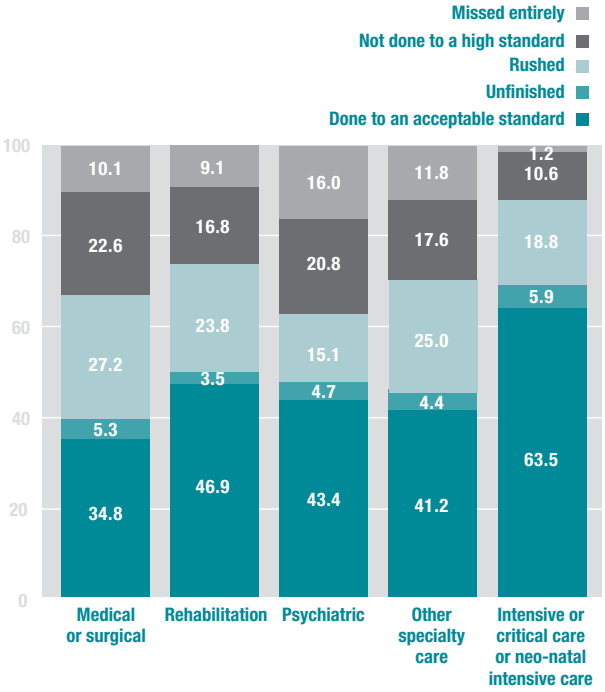
When asked whether they had comforted and talked to patients during their shift, respondents working on intensive or critical care or neo-natal intensive care wards (53.8%) were more likely than respondents from any other ward type to say that the task had been done to an acceptable standard. Respondents working on medical or surgical wards (75.7%) were more likely to say the task was unfinished, rushed, not done to a high standard or missed entirely (table 3.12).

Table 3.12: Comfort or talk with patients



When asked whether they had undertaken oral hygiene during their shift, respondents working on intensive or critical care or neo-natal intensive care wards (63.5%) were more likely than respondents from any other ward type to say the task had been done to an acceptable standard. Respondents working on medical or surgical wards (65.2%) were more likely to say that the task was unfinished, rushed, not done to a high standard or missed entirely (table 3.13).

Table 3.13: Oral hygiene

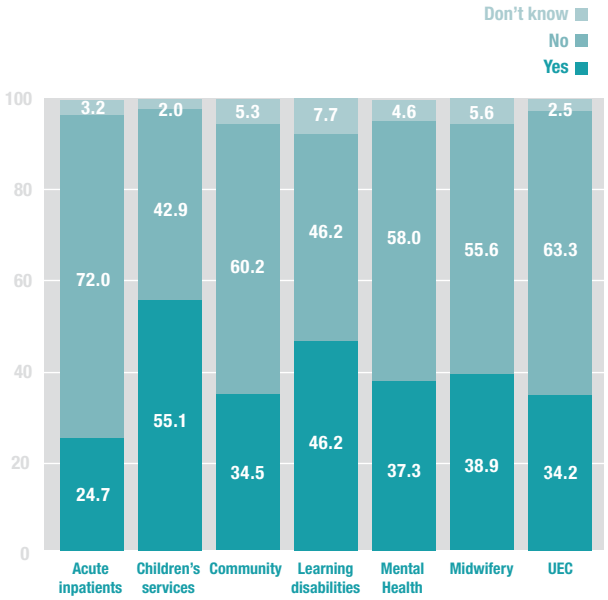


Patient outcomes

Three in five (62.9%) said there were not adequate staff numbers to deliver safe, dignified, compassionate care. Two in five (40.2%) rated the quality of patient care delivered during their shift as poor or fair while over one-quarter (27.2%) rated patient safety during their shift as failing or poor. We will now go on to look at how the responses varied by different settings.

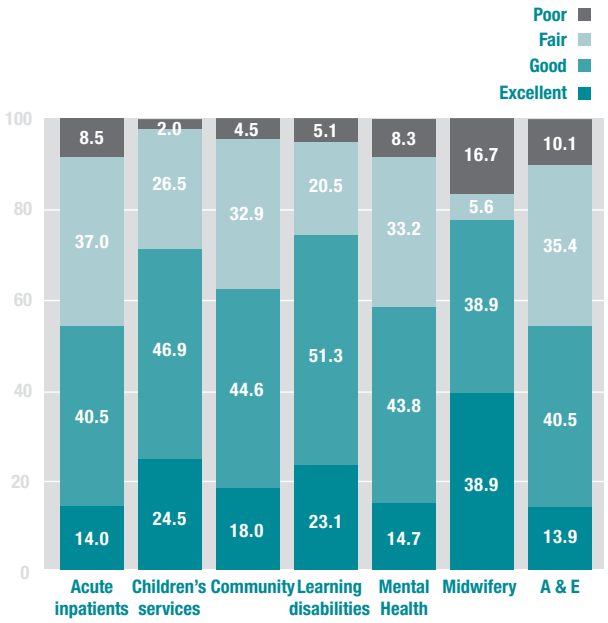
The majority of respondents in all settings felt there were not adequate staff numbers to deliver safe, dignified, and compassionate care. Respondents working in acute inpatients (72%), urgent and emergency care (63.3%), and community (60.2%) were more likely to say there were inadequate staff numbers during their shift on 7 February 2017 (table 4.1).

Table 4.1: Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?



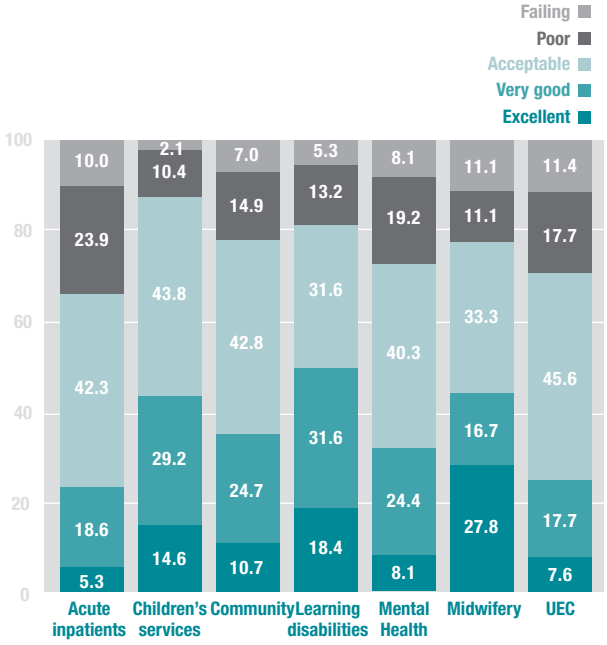
While the majority of respondents across all settings said that the quality of care delivered to patients was good or excellent, respondents working in acute inpatients (45.5%), urgent and emergency care (45.5%), and mental health (41.5%) were more likely to say the quality of care delivered to patients on their unit or ward was poor or fair (table 4.2).

Table 4.2: How would you rate the quality of care delivered to patients on your unit or ward?



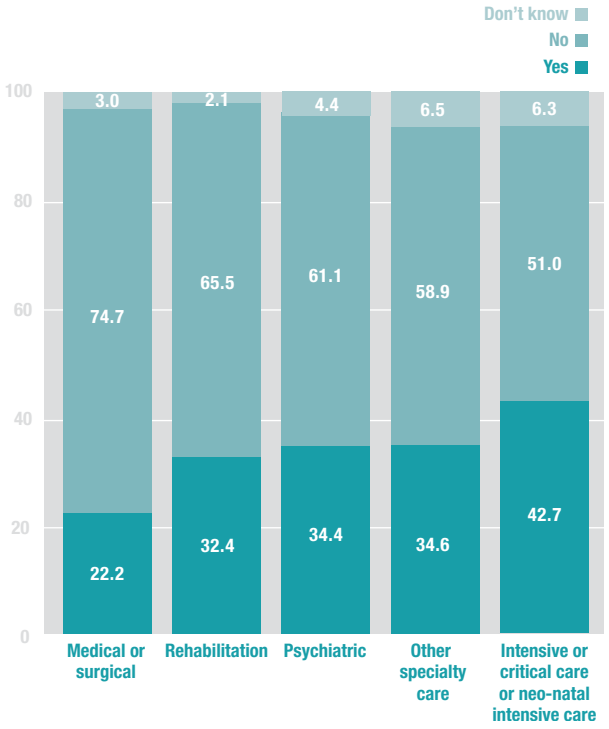
While the majority of respondents across all settings said patient safety was acceptable, very good or excellent, respondents working in acute inpatients (33.9%), urgent and emergency care (29.1%), and mental health (27.3%) were more likely to say patient safety on their unit or ward was failing or poor (table 4.3). We will now go on to look at how responses varied by ward type.

Table 4.3: How would you rate patient safety on your unit or ward?



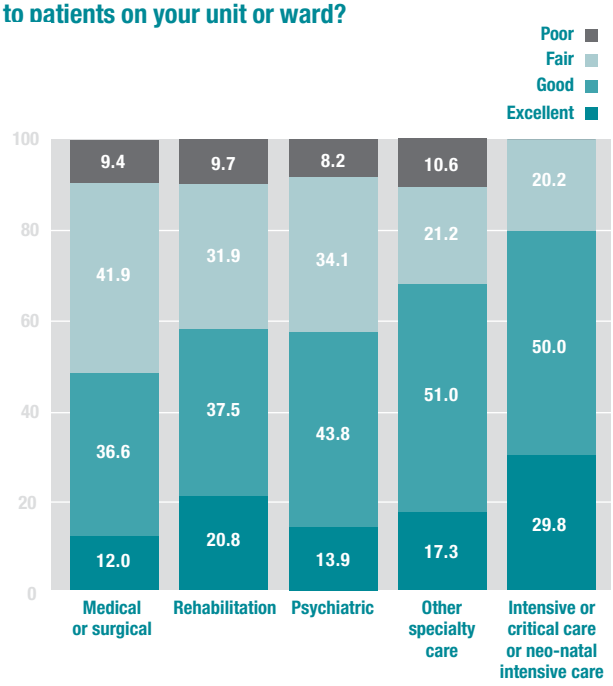
When asked whether they felt that there were adequate staff numbers to deliver safe, dignified, and compassionate care, respondents working on medical or surgical wards (22.2%) were more likely than respondents from other ward types to disagree. However, respondents working on intensive or critical care or neo-natal intensive care wards (42.7%) were more likely than respondents from any other ward type to agree (table 4.4).

Table 4.4: Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?



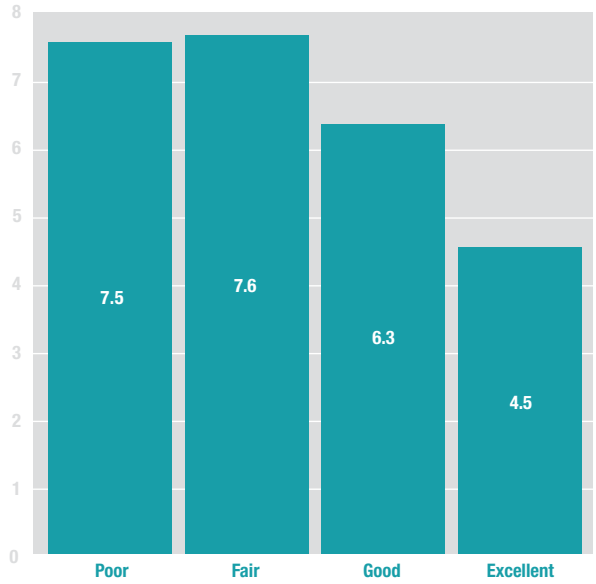
When asked how they would rate the quality of patient care delivered to patients on their unit or ward, respondents working on intensive or critical care or neo-natal intensive care wards (79.8%) were more likely than respondents from any other ward type to say the quality of care delivered was excellent or good and no-one said it was poor (table 4.5).

Table 4.5: How would you rate the quality of care delivered to patients on your unit or ward?



Respondents working on medical or surgical wards (51.3%) were more likely than respondents from other wards to say it was poor or fair (table 4.5). However, when broken down by the average number of patients per registered nurse, it becomes clear that the lower the number of patients per registered nurse the better the quality of care delivered (table 4.6). The closer the number of patients gets to the NNU recommendation of four patients per registered nurse for medical or surgical wards, the better the quality of care.

Table 4.6: Patients per registered nurse by quality of care rating on medical or surgical wards



When asked how they would rate patient safety on their unit or ward, respondents working on intensive or critical care or neo-natal intensive care wards (85.1%) were more likely than respondents from other ward types to say it was excellent, very good or acceptable (table 4.7).

Table 4.7: How would you rate patient safety on your unit or ward?

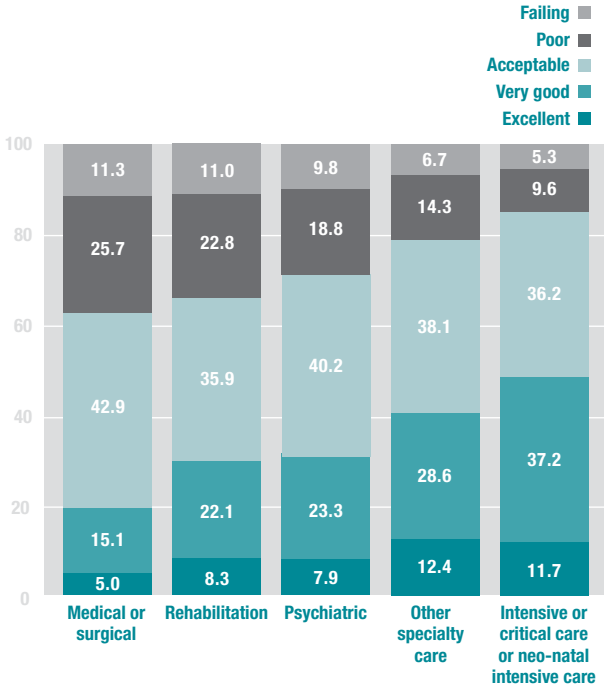
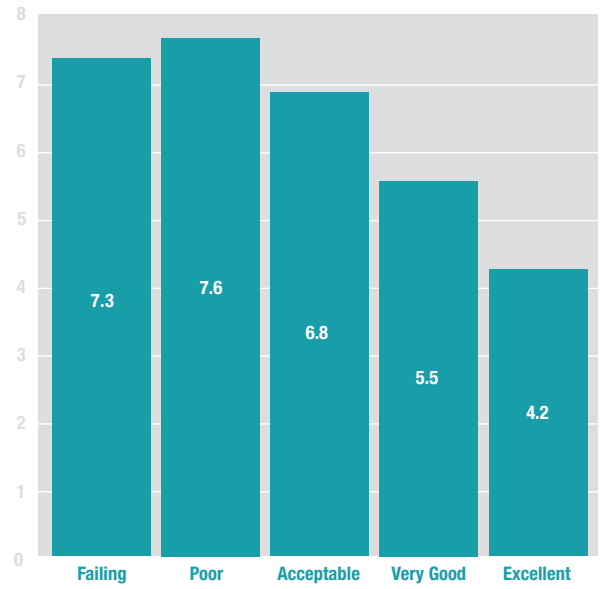


Table 4.8: Patients per registered nurse by patient safety rating on medical or surgical wards



Respondents working on medical or surgical wards (37%) were more likely than respondents from any other ward type to say patient safety on their unit or ward was failing or poor (table 4.7). However, when broken down by the average number of patients per registered nurse, the fewer number of patients per registered nurse the better the rating for patient safety (table 4.8). The closer the number of patients gets to the NNU recommendation of four per registered nurse for medical or surgical wards, the better the patient safety rating.

Staff well-being

While job satisfaction is not significantly associated with nurse-to-patient ratios, job satisfaction is significantly associated with working environment. Views of their working environment are linked to staffing levels.[14] Almost half (47.2%) said they were very or a little dissatisfied with their current job. More than half (53.8%) said they would leave their current job if they could but would still carry on nursing. One in 10 (9.9%) said they did not want to carry on nursing at all. Increased workloads (72.8%), stress at work (72.4%), and unsafe staffing levels (67.6%) are the most relevant factors in their decision to leave.

There is a significant association between burnout and aspects of current working environment and job satisfaction[15]. In order to measure burnout, we have used the Oldenburg Burnout Inventory (OLBI). In this scale, exhaustion and disengagement are used to define burnout. Specifically, the OLBI consists of 16 items, eight of which measure the exhaustion dimension of burnout (eg "There are days when I feel tired before I arrive at work") and eight measuring the disengagement dimension of burnout (eg "It happens

14 http://www.kcl.ac.uk/nursing/research/nnru/publications/reports/rn4cast-nurse-survey-report-27-6-12-final.pdf

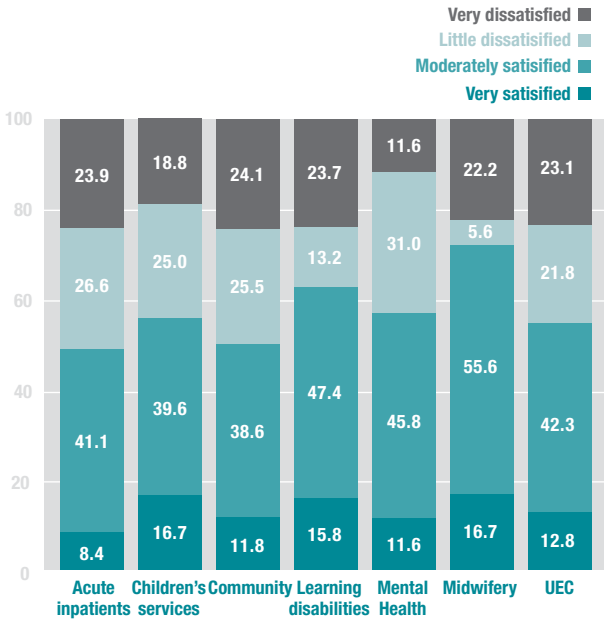
15 http://www.kcl.ac.uk/nursing/research/nnru/publications/reports/rn4cast-nurse-survey-report-27-6-12-final.pdf

more and more often that I talk about my work in a negative way"). Both subscales include four positively worded items and four negatively worded items. Participants were asked to respond to the items by using a scale ranging from one (strongly agree) to four (strongly disagree). In all cases, responses were recorded so that high scores would refer to high levels of exhaustion and disengagement.[16] The average score for disengagement was 2.55 and the average score for exhaustion was 2.83.

Almost three in five (58.4%) said they had raised concerns about unsafe staffing levels during their shift. When asked whether their concerns were listened to, acted upon swiftly, and addressed, almost two-thirds (65%) said that it had not.

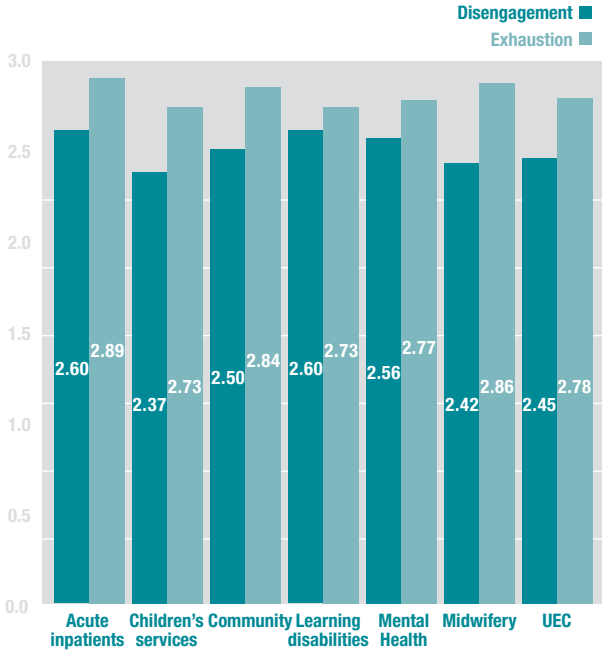
When asked what their overall satisfaction with their current job, the responses varied depending on the setting. However, respondents working in acute inpatients (50.5%), community (49.6%), and urgent and emergency setting (44.9%) were more likely to say they are very or a little dissatisfied with their current job (table 5.1).

Table 5.1: What is your overall satisfaction with your current job?



The average disengagement and exhaustion score did not vary significantly by setting. The average score for disengagement ranged from 2.37 in children's services up to 2.60 in acute inpatients and learning disabilities, while the average score for exhaustion ranged from 2.73 in children's services and learning disabilities up to 2.89 in acute inpatients (table 5.2).

Table 5.2: Disengagement and exhaustion



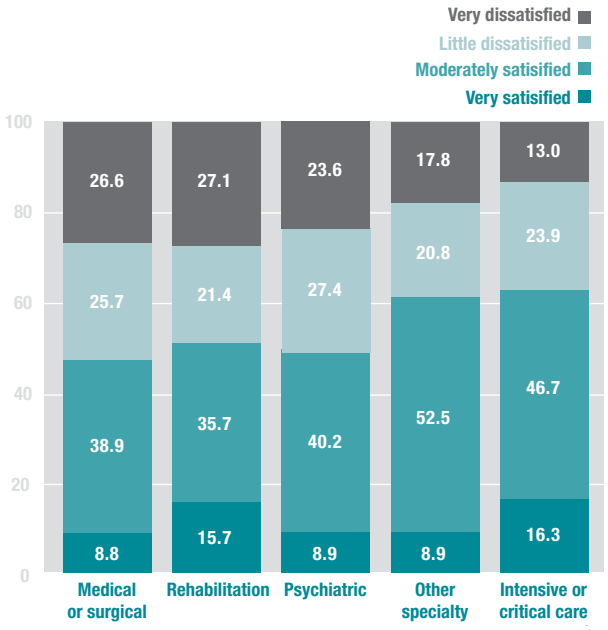
When asked whether they had raised concerns about unsafe staffing levels during their shift, two-thirds (66.6%) in acute inpatients, 55.6% in mental health, 52.0% in urgent and emergency care, half (50.0%) in community, half (50.0%) in learning disabilities, 44.7% in children's services, and 44.4% in midwifery said they had.

When those who had raised concerns were asked whether their concerns had been listened to, acted upon swiftly, and addressed, the majority of respondents from all settings (except learning disabilities) said they had not. However, respondents working in midwifery (75%), acute inpatients (70.1%), and mental health (66.5%) were more likely to say their concerns had not been listened to, acted upon swiftly, and addressed.

16 http://www.sciencedirect.com/science/article/pii/S2213058614000576

When asked what their overall satisfaction is with their current job, respondents working on intensive or critical care or neo-natal intensive care wards (63%) were more likely than respondents from other ward types to say that they are moderately or very satisfied. Respondents working on medical or surgical wards (52.3%) were more likely than respondents from any other ward type to say they are very or a little dissatisfied (table 5.3).

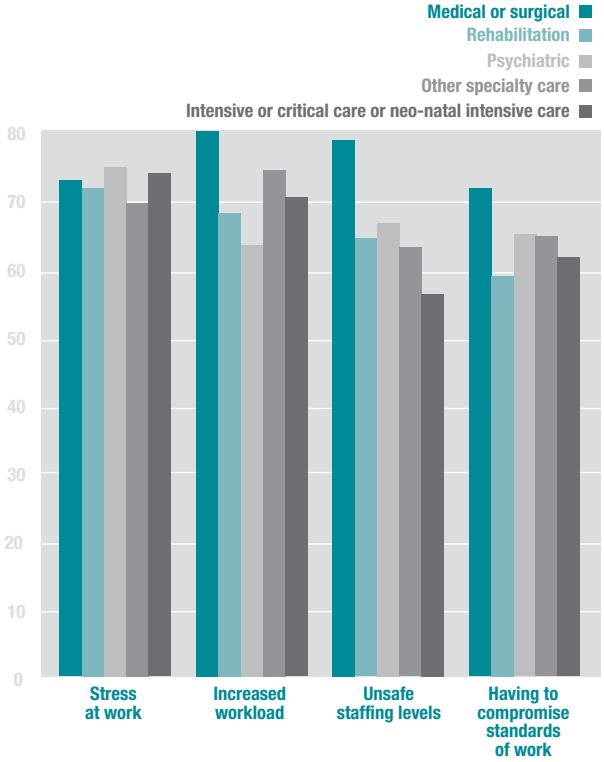
Table 5.3: What is your overall satisfaction with your current job?



There is a significant link between where nurses would like to move to and their level of dissatisfaction. The more dissatisfied, the more likely are they to want to leave nursing altogether[17]. When asked if they would leave their job if they could, respondents working on intensive or critical care or neo-natal intensive care wards (60.2%) were less likely than respondents from other ward types (except other speciality care) to say yes. Respondents working on medical or surgical wards (69.4%) were more likely than respondents from any other ward type to say yes.

When broken down by the factors relevant to their decision to leave if they could, respondents working on intensive or critical care or neo-natal intensive care wards (56.1%) were less likely than respondents from other ward types to say unsafe staffing was a factor. Respondents on medical or surgical wards (78.6%) were more likely to say it was (table 5.4).

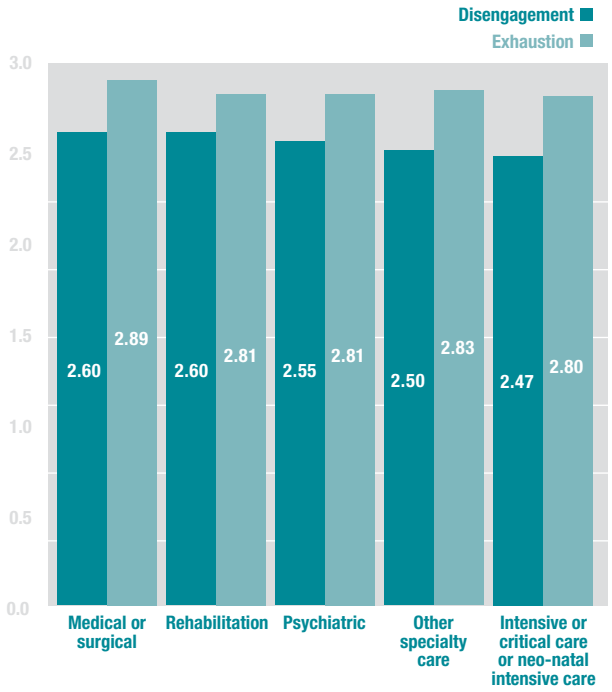
Table 5.4: Which are factors in your decision to leave if you could?



The average disengagement and exhaustion score did not vary significantly by ward type. The average score for disengagement ranged from 2.47 on intensive or critical care or neo-natal intensive care wards up to 2.60 on medical or surgical wards and rehabilitation wards. The average score for exhaustion ranged from 2.80 on intensive or critical care or neo-natal intensive care wards and up to 2.89 on medical or surgical wards (table 5.5).

17 http://www.kcl.ac.uk/nursing/research/nnru/publications/reports/rn4cast-nurse-survey-report-27-6-12-final.pdf

Table 5.5: Disengagement and exhaustion



Conclusion

The average number of patients per registered nurse for all respondents was 13.4. However, this varied significantly by the type of setting and ward. For example, the average number of patients per registered nurse was 5.8 in acute inpatients and 61.9 in community.

Three in five (62.9%) said there were not adequate staff numbers to deliver safe, dignified, compassionate care. Two in five (40.2%) rated the quality of patient care delivered during their shift as poor or fair. Over one-quarter (27.2%) rated patient safety during their shift as failing or poor.

The NICE guide identifies slips, pressure ulcers and medication administration errors as red flag events – an indicator of unsafe staffing levels. Over three in five (60.2%) said slips, trips or falls occurred often or sometimes while almost half (49.4%) said pressure ulcers occurred often or sometimes. Two in five (44.2%) said medication administration errors occurred often or sometimes.

The NICE guide also identifies working overtime, missing breaks and using agency staff frequently as red flag events. Two in five (40.8%) said they worked overtime. Over one-quarter (26.2%) worked more than one additional hour of overtime. Half (50.3%) said they missed all or some of their allocated break or breaks. Almost two-thirds (64.3%) said that agency staff were used often and one-quarter (24.9%) said they were used only sometimes. These are all indicators of unsafe staffing levels.

Another early indicator of unsafe staffing levels is missed care. Respondents were more likely to say developing or updating care plans (69.4%), educating patients and family (66.2%) and comforting or talking to patients (63.2%) was rushed, unfinished, not done to an acceptable standard or missed entirely than other essential nursing tasks.

Almost half (47.2%) said they were very or a little dissatisfied with their current job. More than half (53.8%) said they would leave their current job if they could but would still carry on nursing. One in ten (9.9%) said they did not want to carry on nursing at all. Increased workloads (72.8%), stress at work (72.4%), and unsafe staffing levels (67.6%) are the most relevant factors in their decision to leave. The high average score for disengagement (2.55) and exhaustion (2.83) will also be a factor in their decision to leave.

Almost three in five (58.4%) said they had raised concerns about unsafe staffing levels during their shift. When asked whether their concerns were listened to, acted upon swiftly, and addressed, almost two-thirds (65.0%) said that it had not.

While the majority of respondents from all settings felt there were not adequate staff numbers to deliver safe, dignified, compassionate care, this was more strongly felt by respondents from acute inpatients where the number of patients per registered nurse was on average 5.8 – well within the NICE guide recommendation of never more than eight.

While the majority of respondents across all settings said the quality of patient care on their unit or ward was good or excellent and patient safety on their unit or ward was acceptable, very good or excellent, respondents working in acute inpatients were more likely than those from other settings to say the quality of care was poor or fair, and more likely than respondents from other settings to say patient safety was failing or poor.

Across all settings except children's services, the majority of respondents said the following tasks were unfinished, rushed, not done to a high standard or missed entirely during their shift: educating patients and family; comforting or talking to patients; preparing patients and families for discharge; undertaking oral hygiene; and administering medication on time. Respondents working in the acute inpatients setting were less likely than respondents from other settings to say that these tasks had been done to an acceptable standard during their shift.

Respondents working in acute inpatients were more likely than respondents from other settings to say that slips, pressure ulcers and medication administration errors had occurred often or sometimes during their shift.

Respondents working in the acute inpatients setting were also more likely than respondents from other settings to say their ward or unit often used agency or bank staff, they did not take their entire break or breaks, and they worked overtime. These are other factors that can indicate that there are inadequate staffing levels.

Across all settings, disengagement and exhaustion (burnout) is fairly similar but high. The similarity may be due to other factors contributing to burnout in professional and private lives of nurses. This could include problems with team members, difficulties with childcare and keeping up with house chores, family health problems, economic hardship and transport issues[18] and not just the variation in staffing levels, which is a contributory factor. Nevertheless, the acute inpatients setting had the highest score for disengagement and exhaustion.

Nurses with higher levels of burnout are more likely to be dissatisfied with their jobs[19]. While the majority of respondents across all settings said they are moderately satisfied with their current job, respondents working in acute inpatients were more likely to say that they are a little or very dissatisfied with their current job.

It's clear the government's approach to safe staffing levels is not working. There are not adequate numbers of nurses to deliver safe, compassionate care and the situation is likely to get worse as nurses are considering leaving due to burnout and job dissatisfaction.

The government should establish and introduce legally mandated minimum nurse-to-patient ratios for all healthcare settings similar to those proposed by NNU. Ratios would help improve the recruitment and retention of nurses and ensure greater workforce stability. There would be better patient care, more manageable nursing workloads, increased job satisfaction for nurses, more workplace stability, and reduced stress. It could also help to fuel a growth in student interest in nursing.

The benefits of implementing the ratios can be seen in the responses from nursing staff working on intensive or critical care or neo-natal intensive care wards, which was the only ward type that met the NNU proposed ratio. Respondents working on this ward type were less likely than respondents from any other ward to rate patient safety as poor or failing, or the quality of patient care as poor or fair.

Respondents working on intensive or critical care or neo-natal intensive care wards were also less likely than respondents from any other ward type to say tasks had been unfinished, rushed, not done to a high standard or missed entirely. While nursing staff working on this ward type were just as likely to consider leaving their current job as respondents from other ward types, unsafe staffing levels were less likely to be a factor in their decision to do so.

The NNU recommendation for medical or surgical wards is four patients per registered nurse. The closer the average number of patients per registered nurse got to the NNU recommendation, the better quality of care and patient safety were rated by respondents to the survey. For example, when rating the quality of care delivered, the average number of patients per registered nurse was 4.5 for excellent but 7.5 for poor. If the government is serious about ensuring patient safety, this is further evidence that it must introduce minimum nurse-to-patient ratios to ensure excellent quality of care.

18 https://www.ncbi.nlm.nih.gov/pubmed/14568363

19 http://www.kcl.ac.uk/nursing/research/nnru/publications/reports/rn4cast-nurse-survey-report-27-6-12-final.pdf

Appendix A: profile of respondents

Characteristics	Survey
Age	
Under 25 years (<25)	4.3%
25-34	18.0%
35-44	22.4%
45-54	34.2%
55 and over (55+)	20.7%
Gender	
Female	81.3%
Male	18.7%
Trans or Trans history	
Yes	0.5%
No	93.3%
Prefer not to say	6.3%
Sexual orientation	
Lesbian	0.6%
Bisexual	1.4%
Gay	2.9%
Heterosexual or straight	87.0%
Prefer not to say	8.1%
Ethnicity	
White UK	70.3%
Black or minority ethnic	26.1%
Prefer not to say	3.6%
Disability	
Yes	7.9%
No	88.6%
Prefer not to say	3.5%
Working pattern	
Full-time	75.2%
Part-time	24.8%
UK-trained	**86.4%**
Holds a bachelor's degree in nursing	**36.8%**

Characteristics	Survey
Length of service (years)	
Nursing career	17.0
Current hospital	10.0
Current speciality	9.2
Current ward	6.6
Job title	
Registered nurse	55.5%
Healthcare assistant	31.0%
Sister or charge nurse	8.3%
Other	5.2%
Pay band	
1-4	32.5%
5	44.2%
6	17.4%
7	5.1%
8-9	0.7%
Country of organisation	
England	74.2%
Scotland	14.3%
Wales	6.3%
Northern Ireland	5.2%

Appendix B: survey questions

UNISON's safe staffing level survey 2017

About the survey

Welcome to UNISON's safe staffing level survey. The ratio of nurses to patients (how many patients there are per nurse, in other words) is an issue of utmost importance to patient safety, staff welfare and the service as a whole.

This is our sixth year running this type of 'spot test'. Thanks for taking the time to record your shift's nurse-to-patient ratio on 7 February 2017 and filling in this survey.

The survey will take about 15 minutes to complete. While only six questions are mandatory to answer, it will really help us if you can answer every question. Your evidence helps to show the true work and pressure you are under due to unsafe staffing levels.

UNISON's safe staffing level survey 2017

About your shift on 7 February 2017

* 1. Where did you work during your shift?

- ◯ Acute inpatients
- ◯ Mental health
- ◯ Midwifery
- ◯ Learning disabilities
- ◯ Community
- ◯ Urgent & emergency care (A & E)
- ◯ Children's services
- ◯ Other (please specify)

* 2. What type of ward or unit did you work on?

- ◯ I didn't work on a ward or unit
- ◯ Intensive or critical care or neo-natal intensive care
- ◯ Operating room
- ◯ Post-anesthesia recovery
- ◯ Labour and delivery
- ◯ Antepartum or postpartum couplets or combined labour & delivery, & postpartum
- ◯ Well baby nursery
- ◯ Intermediate care nursery
- ◯ Pediatrics (children)
- ◯ Emergency room
- ◯ ICU Patients in the emergency room
- ◯ Trauma Patients in the emergency room
- ◯ Step down or telemetry
- ◯ Medical or surgical
- ◯ Coronary care or acute respiratory care or burn unit
- ◯ Other specialty care
- ◯ Psychiatric
- ◯ Rehabilitation
- ◯ Skilled nursing facility
- ◯ Other (please specify)

* 3. Total number of patients on your ward or unit (or case load if you didn't work on a ward or unit)

* 4. Total number of registered nurses on your ward or unit (or zero if you didn't work on a ward or unit)

* 5. Total number of healthcare assistants on your ward or unit (or zero if you didn't work on a ward or unit)

6. What shift did you work?

- ◯ Day
- ◯ Afternoon or evening
- ◯ Night

7. How many hours were you rostered to work on that shift?

- ◯ Fewer than 6 hours
- ◯ 6 - 7:59 hours
- ◯ 8 - 9:59 hours
- ◯ 10 - 11:59
- ◯ 12 or more hours

8. Did you work longer than your rostered hours?

- ◯ Yes
- ◯ No

UNISON's safe staffing level survey 2017

About your shift on 7 February 2017

9. How many additional hours did you work?

- ◯ Up to 1 hour
- ◯ Up to 2 hours
- ◯ More than 2 hours

10. Did your shift include one or more breaks?

- ◯ Yes
- ◯ No

UNISON's safe staffing level survey 2017

About your shift on 7 February 2017

11. Did you have time to take your allocated break or breaks during your shift?

- ◯ I had all my break or breaks
- ◯ I had some of my break or breaks
- ◯ I did not have time to take any break or breaks

12. Was this a typical shift?

- ◯ Yes, it was a typical shift
- ◯ No, It was busier than usual
- ◯ No, it was quieter than usual
- ◯ I don't know

UNISON's safe staffing level survey 2017

Quality of care and patient safety on 7 February 2017

13. Did you feel that there were adequate staff numbers to deliver safe, dignified, compassionate care?

- ◯ Yes
- ◯ No
- ◯ I don't know

14. During your shift, to what extent were the following necessary activities completed?

	Done to an acceptable standard	Unfinished	Rushed	Not done to a high standard	Missed entirely	Not applicable
Comfort or talk with patients	○	○	○	○	○	○
Educating patients and family	○	○	○	○	○	○
Develop or update nursing care plans or care pathways	○	○	○	○	○	○
Adequate patient surveillance	○	○	○	○	○	○
Adequately document nursing care	○	○	○	○	○	○
Oral hygiene	○	○	○	○	○	○
Frequent changing of patient position	○	○	○	○	○	○
Planning care	○	○	○	○	○	○
Administer medications on time	○	○	○	○	○	○
Skin care	○	○	○	○	○	○
Prepare patients and families for discharge	○	○	○	○	○	○
Treatments and procedures	○	○	○	○	○	○
Pain management	○	○	○	○	○	○

15. How would you rate the quality of care delivered to patients on your unit or ward?

- ○ Poor
- ○ Fair
- ○ Good
- ○ Excellent

16. How would you rate patient safety on your unit or ward?

- ◯ Failing
- ◯ Poor
- ◯ Acceptable
- ◯ Very good
- ◯ Excellent

17. How frequently did the following incidents occur on your unit or ward?

	Often	Sometimes	Never	I don't know
Slip, trip or fall	◯	◯	◯	◯
Pressure ulcers	◯	◯	◯	◯
Medication administration errors	◯	◯	◯	◯
Mortality	◯	◯	◯	◯

18. Tell us what it was like to work on your shift

UNISON's safe staffing level survey 2017

Job satisfaction

19. What is your overall satisfaction with your current job?

- ◯ Very dissatisfied
- ◯ Little dissatisfied
- ◯ Moderately satisfied
- ◯ Very satisfied

20. Would you leave your current job if you could

- ○ Yes, I would leave for another position in my organisation
- ○ Yes, I would carry on nursing but in another organisation within the NHS
- ○ Yes, I would take up bank or agency work as my main source of income
- ○ Yes, I would take up a post in the private or independent healthcare sector
- ○ Yes, I would take retirement
- ○ Yes, I don't want to carry on nursing at all
- ○ No
- ○ I don't know
- ○ Other (please specify)

UNISON's safe staffing level survey 2017

Job satisfaction

21. Which of the following are factors in your decision to leave if you could?

- ☐ Unsafe staffing levels
- ☐ Feeling undervalued due to low levels of pay
- ☐ Feeling undervalued due to job grading
- ☐ Feeling undervalued by management
- ☐ Increased workload
- ☐ Having to compromise standards of work
- ☐ Problems with patterns of working hours
- ☐ Restructures and reorganisations
- ☐ Stress at work
- ☐ Lack of career or promotion prospects
- ☐ An offer of voluntary redundancy
- ☐ Other (please specify)

UNISON's safe staffing level survey 2017

How your job makes you feel

22. To what extent do you agree or disagree with the following statements?

	Strongly agree	Agree	Disagree	Strongly disagree
I always find new and interesting aspects of my work	○	○	○	○
I can tolerate the pressure of my work very well	○	○	○	○
I find my work to be a positive challenge	○	○	○	○
After working, I have enough energy for my leisure activities	○	○	○	○
This is the only type of work I can imagine myself doing	○	○	○	○
Usually, I can manage the amount of my work well	○	○	○	○
I feel more and more engaged in my work	○	○	○	○

23. To what extent do you agree or disagree with the following statements?

	Strongly agree	agree	disagree	Strongly disagree
There are days when I feel tired before I arrive at work	○	○	○	○
It happens more and more often that I talk about my work in a negative way	○	○	○	○
After work, I tend to need more time than in the past in order to relax and feel better	○	○	○	○
Lately, I tend to think less at work and do my job almost mechanically	○	○	○	○
During my work, I often feel emotionally drained	○	○	○	○
Over time, one can become disconnected from this type of work	○	○	○	○
Sometimes I feel sickened by my work tasks	○	○	○	○
After my work, I often feel worn out and weary	○	○	○	○
When I work, I usually feel energized	○	○	○	○

24. To what extent do you agree or disagree with the statements below?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I regularly worry about money to cover basic expenses	○	○	○	○	○
I feel able to concentrate on work without worrying about finances	○	○	○	○	○

UNISON's safe staffing level survey 2017

Your place of work

25. Does your ward or unit have a set minimum ratio for nurses to patients?

- Yes
- No
- I'm not sure

26. What is the minimum registered nurse-to-patient ratio for your ward or unit?

- The ratio is 1:1
- The ratio is 1:2
- The ratio is 1:3
- The ratio is 1:4
- The ratio is 1:5
- The ratio is 1:6
- The ratio is 1:7
- The ratio is 1:8
- The ratio is more than 1:8

27. How frequently does your ward or unit use agency or bank staff?

- Often
- Sometimes
- Never

28. Did you raise concerns about unsafe staffing levels on your ward or unit during your shift?

- Yes
- No

29. Were your concerns listened to, acted upon swiftly, and addressed?

- Yes
- No
- I don't know

UNISON's safe staffing level survey 2017

Policy

30. To what extent do you agree or disagree with the following statement?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The government should introduce legally-enforced nurse-to-patient ratios that organisations must comply with					

UNISON's safe staffing level survey 2017

About you

31. Age

- Under 25 years (<25)
- 25-34
- 35-44
- 45-54
- 55 and over (55+)

32. Gender

- Female
- Male

33. Do you identify as Trans or have a Trans history?

- ◯ Yes
- ◯ No
- ◯ Prefer not to select

34. Do you identify as:

- ◯ Lesbian
- ◯ Bisexual
- ◯ Gay
- ◯ Heterosexual or straight
- ◯ Prefer not to say

35. How do you describe yourself?

- ◯ White British or English or Scottish or Welsh or Northern Irish
- ◯ White Irish
- ◯ White Other
- ◯ Black British or English or Scottish or Welsh or Northern Irish
- ◯ Black Caribbean
- ◯ Black African
- ◯ Black Other
- ◯ Mixed or Multiple Ethnic Groups
- ◯ Asian British or English or Scottish or Welsh or Northern Irish
- ◯ Indian
- ◯ Pakistani
- ◯ Bangladeshi
- ◯ Chinese
- ◯ Filipino
- ◯ Asian Other
- ◯ Arab
- ◯ Prefer not to answer
- ◯ Any other background (please specify)

36. Do you have a disability?

- ◯ Yes
- ◯ No
- ◯ Prefer not to select

37. Where did you train?

- ◯ United Kingdom (UK)
- ◯ European Economic Area (EEA)
- ◯ Outside the European Economic Area (EEA)

38. Holds a bachelor's degree in nursing

- ◯ Yes
- ◯ No

39. Working hours

- ◯ Full-time
- ◯ Part-time

40. Length of service (years)

Nursing career	
Current hospital	
Current speciality	
Current ward	

41. Job title

- ◯ Registered nurse
- ◯ Healthcare assistant or assistant practitioner or support worker
- ◯ Midwife
- ◯ Sister or charge nurse
- ◯ Student
- ◯ Apprentice
- ◯ Other (please specify)

42. Pay band?

- ◯ Bands 1-4
- ◯ Band 5
- ◯ Band 6
- ◯ Band 7
- ◯ Band 8/9

About your organisation

43. What is the name of the organisation that you work for?

* 44. What UK country is your organisation in?

- ◯ England
- ◯ Scotland
- ◯ Wales
- ◯ Northern Ireland

UNISON's safe staffing level survey 2017

Contact details

45. Please provide your contact details if you are willing to share your story as a UNISON case study?

Name:

Email:

Telephone:

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